Action for Mental Health and Substance-Related Disorders

Improving Services for Individuals at Risk of, or with, Co-occurring Substance-Related and Mental Health Disorders

Conference Report and Recommended National Strategy

of the SAMHSA National Advisory Council

Rockville, Maryland
January 1997

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration

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and

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Preamble

This conference report and proposed **National Strategy** reflect the deliberations of over 140 expert participants attending the National Conference **"Improving Services: Co-Occurring Substance Abuse and Mental Health Disorders."** The conference was convened by the Substance Abuse and Mental Health Services Administration (SAMHSA) in November 1995, in collaboration with its National Advisory Council.

SAMHSA's National Advisory Council operates under the authority of the Public Health Service Act, Section 502.(1)(A). It is charged with advising, consulting with, and making recommendations to the Secretary, U.S. Department of Health and Human Services (DHHS) and the Administrator, SAMHSA concerning matters relating to the activities carried out by and through the Administration and the policies respecting such activities. The November 1995 conference was specifically authorized by the Public Health Service Act, Section 502(2)(C).

The recommendations in this report are the products of six substantive conference tracks. They reflect the knowledge and opinions of those experts who contributed to the track discussions. Staff recorders were present in each substantive track. The recommendations are the result of a synthesis of the general sense and intent of the group. No consensus was sought; no votes were taken.

The **goals, objectives, and strategies** in the **National Strategy** are based on track recommendations as complemented by input solicited and received from a reviewer panel composed of Federal and non-Federal experts from the field (appendix D). These recommendations do not necessarily reflect SAMHSA's official position or that of any other part of DHHS.

The report, as submitted by the Council to the Secretary, HHS, was circulated among a small group of stakeholder organizations. Based on their reactions, certain organizations were asked to submit comments on this report for issuance with the Conference Report. Comments were solicited from the National Institutes of Health (NIH); SAMHSA's Office of the Administrator, Center for Mental Health Services (CMHS), Center for Substance Abuse Treatment (CSAT), and Center for Substance Abuse Prevention (CSAP); the CSAT National Advisory Council, and the report's author, Bert Pepper, M.D. Comments received as a result of that solicitation may be found in appendix E.

Acknowledgments

The Substance Abuse and Mental Health Services Administration (SAMHSA) wishes to express its gratitude to the participants in the national conference on *Improving Services: Co-Occurring Substance Abuse and Mental Health Disorders*, to the expert review panel, which volunteered valuable time and expertise to the development of this document, and to the SAMHSA Advisory Council members and SAMHSA staff, without whose unfailing personal dedication to conference implementation and followup activities this blueprint for the future would not have been possible.

Special thanks are extended to Max Schneier, J.D., Co-Chair of the SAMHSA Council Subcommittee on Services Integration, for his powerful insight and purposeful guidance; to Bert Pepper, M.D., Director, The Information Exchange, Inc., for his expert technical advice and written materials; to Ms. Roberta Messalle, Program Analyst, Center for Substance Abuse Treatment, for her tireless efforts in designing and planning the event; and to Ms. Barbara Wagner, Office of Policy and Program Coordination, SAMHSA, for managing the myriad responsibilities necessary to implementing a successful national conference and producing a strategy for the nation.

A job well done.

Nelba Chavez, Ph.D.
Administrator

Foreword

This document serves a dual purpose. Overall, it is the report of a national conference on **"Improving Services: Co-Occurring Substance Abuse and Mental Health Disorders"** that was convened by the Substance Abuse and Mental Health Services Administration in November 1995. Importantly, embedded in this document is the recommended **National Strategy for Improving Services to Individuals with Co-Occurring Substance-Related and Mental Disorders** (National Strategy).

The strategy was developed from the expert advice and opinions of over 140 researchers, clinicians, administrators, consumers, family members, and policy makers who attended that November conference and who shared an overwhelming wealth of knowledge gained by virtue of their training, education, and experience with these disorders.

The status quo with regard to services and service provision for co-occurring substance-related and mental disorders is broken.

Today must be the turning point for the nearly 10 million people who have both a substance-related and a mental health disorder, and for the millions more who already have one disorder and are at increased risk of getting others, all of whom need access to quality services.

Today must be the turning point for the clinicians, program administrators, and systems administrators striving daily to best meet the multiple needs of such people in disparate, often competing environments.

Today must be the turning point for the policy makers at Federal, State, and local levels who must make difficult choices in times of rapid change, but in whose hands lies the future of the Nation.

From this day forward the existence of millions of individuals with co-occurring substance-related and mental disorders is hereby acknowledged: They **exist,** they need **preventive, treatment, and rehabilitative services,** and **they are part of us.**

We are accumulating knowledge about co-occurring substance-related and mental disorders at an unprecedented rate, and must find new ways of transforming what we are learning into everyday practice. We are challenged by reforms in health care delivery, the growth of managed care, and new ways to finance services. Our resources are limited and we are compelled to reduce costs. Change is the rule,

thus flexibility must be the response. And so we proceed, aware that the fragmented policies and short-term fixes of the past are no longer adequate to the task and that progress can be achieved only if the private and public sectors work together toward implementing a long-range, comprehensive strategy to improve services for co-occurring disorders.

The conference report and recommended National Strategy that follow are the product of a yearlong effort on the part of Federal and non-Federal professionals with interest and expertise in services and service delivery for co-occurring substance-related and mental health disorders. Culminating in a national conference, this work has produced a dual document:

1. A **conference report** that reflects conference proceedings and discussions, and

2. A **recommended National Strategy** that is intended to provide guideposts and a catalyst for necessary action on the part of Federal, State, and local level agencies, public and private practitioners, payors, program administrators, and policy makers alike.

Consumers and their families also have an important role to play. While consensus was not reached in all track discussions, the general thrust of deliberations has been captured herein.

The recommended **National Strategy** stops short of directing action. Rather, it establishes broad goals and identifies strategies to achieve them; strategies that must be supported by action steps at various levels. Action steps must be identified by the actors themselves, taking into consideration the specific and unique environmental, political, and economic factors that influence their ability to take action.

We are hopeful that this clarion call is heard across the land and that the challenge to fix the broken status quo is accepted at all levels.

Executive Summary

The most common cause of psychiatric relapse today is the use of alcohol, marijuana, and cocaine. The most common cause of relapse to substance use/abuse today is untreated psychiatric disorder.

The National Advisory Council of the Substance Abuse and Mental Health Services Administration (SAMHSA) is calling the Nation's attention to an emerging national problem: millions of individuals with **co-occurring substance-related and mental health disorders.** These individuals and their families are among the most frequent users of expensive health care services. Their needs have not been addressed by the majority of mental health and substance abuse treatment programs. A concerted **national strategy** is required on their behalf.

SAMHSA is providing leadership in the creation and implementation of a National Strategy to improve prevention, treatment, and rehabilitation services. It began the process by bringing together knowledgeable experts to propose a strategy. This document is the report of the conference and the recommended National Strategy document that emerged from it. SAMHSA intends to propel the National Strategy forward.

Background

The available data: In 1990, Congress appropriated funds to the National Institute of Mental Health (NIMH) to survey the problem of co-occurring disorders, and the task was contracted to the University of Michigan's Survey Research Center. The National Co-morbidity Survey (NCS)[1] was built upon the results of a 1984 survey carried out by the NIMH and five collaborating medical centers. That earlier work, the Epidemiological Catchment Area (ECA) Study,[2] provided the Nation's first quantitative information on co-morbidity.

The magnitude of the problem: The combined results of the ECA Study and the NCS[3] indicate that **up to 10 million persons in the United States have at least**

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[1]Kessler, R., McGonagle, K. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Archives of General Psychiatry 1994; 51: 8–18.

[2]Robins, L.N., Regier, D.A. Psychiatric Disorders in America: The Epidemiological Catchment Area Study. New York: Free Press, 1991.

[3]Kessler, R. The Epidemiology of Co-Occurring Addictive and Mental Disorders. NCS Working Paper #9. Invited conference paper, presented at the SAMHSA-sponsored conference Improving Services for Individuals with Co-Occurring Substance Abuse and Mental Health Disorders, 11/13/95.

one mental disorder and at least one substance-related disorder in any given year. This estimate includes individuals of all ages who are living in the community or in institutions. If not treated early and effectively, these disorders may become chronic; may lead to other disorders, may increase symptoms by interacting with each other, may cause disability, and are likely to increase the costs of care.

Data from the NCS indicate that in the vast majority of individuals with co-occurring substance abuse and mental health disorders, the mental disorder develops first, often in the preteen or early teen years.[4] The substance abuse disorder develops, on average, a few years later. Of course, ages of onset vary considerably by gender, geography, culture, and as yet undetermined factors. The time after the development of the first disorder offers an obvious opportunity to prevent a second disorder, if attention is paid to children and adolescents who are exhibiting problems.

Recent decades have seen significant changes in

- **family structure,** including increased numbers of single parent families, working mothers, children of divorce, children living in poverty;

- **technology,** including increased use of computers and automation, resulting in fewer unskilled and semiskilled jobs;

- **globalization** of the economy and communications; and

- **greater acceptability and availability** of cocaine, alcohol, and marijuana among young persons.

These changes may be contributing to the apparent increase in anxiety and depressive disorders noted in the NCS. They may also be contributing to our long-standing alcoholism problems and to recent increases in the use of marijuana, heroin, and other drugs among our youth, many of whom are already struggling with depression, anxiety, and psychotic disorders.

The problems noted above require immediate and concerted attention by government and the private sector. The mental health and alcohol and drug-related disorders treatment fields are now focusing needed attention on the problems

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[4]Kessler, R., Nelson, C., McGonagle, K. The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. American Journal of Orthopsychiatry 1996; 66: 17–31.

associated with the identification, prevention, and treatment of co-occurring disorders and rehabilitation of individuals with those disorders.

Where are the millions of individuals who meet the criterion of at least one mental health and one substance-related disorder? Many are currently occupying a jail or prison cell, or are on parole or probation. Many are homeless. But the majority are not in institutions or on the street; they are at home, with their families.

The asylum of old—the state mental hospital—is no longer a readily available option. There were 92,000 state and county mental hospital beds left in the nation in 1990, down from 559,000 in 1955.[5] This 84% loss of beds has taken place during the same 4 decades in which the U.S. population has grown by 100 million persons.[6] On the other hand, **the population of incarcerated persons** has ballooned. The U.S. Department of Justice (DOJ) reported that as of June 1994, there were over 1 million individuals in State and Federal prisons and about 500,000 in local jails.[7] Other data indicate that an exceedingly high percentage of inmates have co-occurring substance-related disorders and mental health disorders.[8] Taken together, these data lead toward the conclusion that **deinstitutionalization** unintentionally contributed to increased **homelessness** and **transinstitutionalization** from hospital to prison.

As a Nation, we must be concerned with the economic and social costs of homelessness and crime. We must also pay attention to the estimated 7.2 million persons between the ages of 18 and 54 with co-occurring disorders who are living in households.[9] A majority are receiving no treatment at the present time, not even in the general health sector.[10] A minority are being treated by clinicians trained to treat **either** mental health **or** substance-related disorders. The number who are receiving care by clinicians trained to treat them in an integrated and effective

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[5]Regier, D.A. Epidemiology, in Kaplan and Sadock, Comprehensive Textbook of Psychiatry 1992; 390–392. Pepper, B., Massaro, J. Trans-institutionalization: Substance abuse and mental illness in the criminal justice system. Tie-Lines 1992; 9(2): 1–4.

[6]U.S. Census Bureau, annual U.S. census summary.

[7]Holmes, S.A., The New York Times, 10/28/94, p. 1.

[8]Regier, D.A., Farmer, M.E., Rae, D., Locke, B.Z., Keith, S.J., Judd, L.L., Goodwin, F.K. Comorbidity of mental disorders with alcohol and other drug abuse. Journal of American Medical Association 1990; 246(19): 2511–2518. Chiles, J.A., Von Cleve, E., Jemelka, R.P., Trupin, E.W. Substance abuse and psychiatric disorders in prison inmates. Hospital and Community Psychiatry 1990; 41(10): 1132–1134.

[9]Kessler, R., Nelson,C., McGonagle, K. The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. American Journal of Orthopsychiatry 1996; 66: 17–31.

[10]Kessler, R. The Epidemiology of Co-Occurring Addictive and Mental Disorders. NCS Working Paper #9. Invited conference paper, presented at the SAMHSA-sponsored conference Improving Services for Individuals with Co-Occurring Substance Abuse and Mental Health Disorders, 11/13/95.

manner is generally agreed by experts[11] to be very small, although no data are available on this point.

Data on treatment from the NCS suggest that three million individuals with co-occurring disorders have at least three disorders, and one million have four or more disorders. As the number of disorders increases, the likelihood of serious and persistent mental illness, disability, and heavy use of health and social services also increases.[12]

SAMHSA in Action: Convening the November 1995 Conference

To secure the expertise needed for the creation of a **national strategy** for change, the SAMHSA Administrator and Advisory Council convened 141 experts and federal staff for a 2-day invitational conference on November 13 and 14, 1995, in Washington, DC.

The conferees were organized into six tracks:

Track 1: Data and Research
Track 2: Best Prevention and Treatment Practices
Track 3: Education and Training
Track 4: Children and Adolescents
Track 5: Homelessness and Criminal Justice
Track 6: Financing and Managed Care

The experts in the Homelessness and Criminal Justice Track divided themselves into two tracks because of the differences between their populations. As a result, recommendations were generated from seven tracks.

1. **The panel of experts:** Members were selected to reflect ethnic, cultural, and geographic diversity. They included consumers, providers, and family members. The experts made hundreds of recommendations in the seven track areas. Each track urged sensitivity to ethnic, cultural, and gender issues. The primary recommendation from each track follows:

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[11]Drake, R.E., Mueser, K.T., Clark, R.E., Wallach, M.A. The course, treatment, and outcome of substance disorder in persons with severe mental illness. American Journal of Orthopsychiatry 1996; 66(1): 42–51.
[12]Kessler, R. The Epidemiology of Co-Occurring Addictive and Mental Disorders. NCS Working Paper #9. Invited conference paper, presented at the SAMHSA-sponsored conference Improving Services for Individuals with Co-Occurring Substance Abuse and Mental Health Disorders, 11/13/95.

- **Track 1:** Developing and coordinating plans to conduct the **research** necessary to gather and analyze the additional **data** needed about co-occurring disorders, their consequences, and their treatment and rehabilitation.

- **Track 2:** Improving treatment and rehabilitation by moving to **integrated treatment services** for the whole person, rather than sequential or collaborative treatment.

- **Track 3: Training substance abuse and mental health clinicians** to identify and treat multiple disorders in an integrated, effective manner.

- **Track 4: Meeting the needs of children** and adolescents by responding to the early age of onset of children's disorders, and noting that lack of prompt treatment for the first disorder may set the stage for multiple disorders.

- **Track 5: Responding to** the additional special needs, beyond mental health and addiction treatment, of **homeless persons** with co-occurring disorders.

- **Track 6: Responding to** the special circumstances of individuals in the **juvenile and adult justice system** who have co-occurring disorders.

- **Track 7: Responding to** the impact of **changing funding** for health services—including **managed care**—on services to persons with co-occurring disorders.

Moving Toward a National Strategy

The above seven recommendations, as well as the many others, have been forged into a focused **National Strategy** document that immediately follows this Executive Summary.

The **National Strategy** is organized around four main goals:

Goal I: Data and Research
Goal II: Best Prevention and Treatment Practices
Goal III: Training and Education
Goal IV: Financing and Managed Care

The recommended **National Strategy** offers several **objectives** for each **goal,** and several **strategies** for each objective. Objectives and strategies that are specific to the three special populations—children and adolescents, the homeless, and those in the juvenile and adult criminal justice systems—were placed within each of the

four goals, in order to maintain a consistent goal structure. The complete recommendations of each of the seven tracks appear as a separate section in Chapters II through VIII, respectively. The detailed **action steps** suggested by the experts are to be found there.

Additional Steps: SAMHSA's Commitment to Action

It is recommended that SAMHSA, in order to initiate the National Strategy and to share responsibilities with other public and private agencies, carry out the following key **Action Steps:**

- **Create a team responsible for supporting implementation of the National Strategy.** The establishment of this team acknowledges and legitimatizes the population of individuals with co-occurring mental health and substance-related disorders.

- **Seek to reconvene the expert panel** to meet with other Department of Health and Human Services agencies, the Office of National Drug Control Policy, DOJ, members of Congress and other public officials, and representatives of family, consumer, and professional organizations.

The reconvening of the expanded expert panel will seek to assure that other agencies accept responsibility for the parts of the National Strategy that fall within their areas of concern. The National Strategy is intended to be a widely shared and supported effort, initiated by SAMHSA but carried out by many.

In this era of increased national and global complexity, the public and private sectors must work together for solutions to national concerns. These solutions should be based on a broad and deep understanding of the problem, and should utilize the most economical and effective paths to reduce health, social, and economic burdens.

The National Strategy

for

Improving Services to Individuals with Co-Occurring Substance-Related and Mental Disorders

This document arose from the recommendations

of a panel of experts convened by the

Substance Abuse and Mental Health Services Administration

in Washington, DC, on November 13–14, 1995

The National Strategy

The Need for a National Strategy

The Substance Abuse and Mental Health Services Administration (SAMHSA) is impelled to call national attention to the urgent, unmet service needs of the millions of U.S. citizens who suffer from **co-occurring substance-related and mental health disorders.** This population has surged in the past few years, confounding and overtaxing both mental health and substance abuse treatment programs. Despite the magnitude and severity of the problem, it has not been adequately acknowledged or responded to by either the public or private sector.

By the best estimate of the directors of the National Co-morbidity Survey (NCS) and the Epidemiologic Catchment Area Study (ECA), there are about **ten million individuals** in the United States **who have co-occurring substance-related and mental health disorders.** Each subgroup within this population creates special problems for prevention and treatment services:

- According to data from the ECA, **47% of schizophrenic** patients and **61% of bipolar** (manic-depressive) patients have a substance-related disorder.[13]

- According to data from the NCS, between 41% and 65.5% of those with an addictive disorder also have at least one mental disorder, and 51% of those with a mental disorder have at least one addictive disorder.[14]

- Individuals with co-occurring disorders seek treatment more frequently than those with only one disorder.[15]

- More than 40% of those with **three or more** disorders have never received **any treatment.**[16]

The NCS data have important public health implications for both prevention and treatment:

- In the population with co-occurring mental health and substance-related disorders, the mental disorder developed first in the vast majority of cases.

- The mental disorder tended to develop before or during the teen years.

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[13]Regier, D.A., Farmer, M.E., Rae, D., Locke, B.Z., Keith, S.J., Judd, L.L., Goodwin, F.K. Comorbidity of mental disorders with alcohol and other drug abuse. Journal of American Medical Association 1990; 246(19): 2511–2518.
[14]Kessler, R., Nelson, C., McGonagle, K. The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. American Journal of Orthopsychiatry 1996; 66: 17–31.
[15]Narrow, W.E., Regier, D.A., Rae, D.S., Manderscheid, R.W., Locke, B.Z. Use of services by persons with mental and addictive disorders 1993. Archives of General Psychiatry 1993. 50: 95–107.
Regier, D.A., Narrow, W.E., Rae, D.S., Manderscheid, R.W., Locke, B.Z., Goodwin, F.K. The de facto US mental and addictive disorders service system. Archives of General Psychiatry 1993; 50: 85–94.
[16]Kessler, R., McGonagle, K., Zhao, et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Archives of General Psychiatry 1994; 51: 8–19.

- The substance-related disorder tended to develop several years later, in the late teens or the early 20s.[17]

It must be stressed that there are wide variations in age of onset.[18] That the mental disorder develops first in the vast majority of cases, and that the substance-related disorder develops some years later provide some indirect support for the self-medication hypothesis of the etiology of some instances of substance-related disorders. It also points to a vitally important **window of opportunity:**

> **Early intervention with children and adolescents who have developed mental disorders may prevent the later development of a substance-related disorder, and thus may prevent co-occurring disorders.**

This hypothesis has not been tested, but offers a promising line of investigation for clinicians and researchers interested in prevention strategies.[19]

While the economic costs associated with co-occurring disorders have not been calculated, they are substantial and are known to contribute to rising health care costs. In human terms, the costs cannot be measured. Co-occurring disorders routinely confound those whose lives are touched by them. The affected individual typically has numerous serious problems, but often does not understand the complex interactivity between the disorders. As a result, there is often confusion and disagreement about cause, cure, responsibility, and remedy.

- Most individuals with co-occurring disorders do not understand how their interacting disorders produce their painful symptoms. Depression, low self-esteem, anxiety, and panic are commonplace. Unemployment, multiple hospitalizations, failures in mental health and/or substance abuse treatment—to the extent that treatment is available—are equally common.

- Families, friends, substance abuse counselors, mental health therapists, friends, and the community may share in the bewilderment of the individual suffering from co-occurring disorders.

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[17]Kessler, R. The Epidemiology of Co-Occurring Addictive and Mental Disorders. NCS Working Paper #9. Invited conference paper, presented at the SAMHSA-sponsored conference Improving Services for Individuals with Co-Occurring Substance Abuse and Mental Health Disorders, 11/13/95.
Kessler, R., Price, H. Primary prevention of secondary disorders: A proposal and agenda. American Journal of Community Psychology 1993; 21(S): 607–631.
[18]Kessler, R. The Epidemiology of Co-Occurring Addictive and Mental Disorders. NCS Working Paper #9. Invited conference paper, presented at the SAMHSA-sponsored conference Improving Services for Individuals with Co-Occurring Substance Abuse and Mental Health Disorders, 11/13/95.
[19]Kessler, R. The National Comorbidity Survey: Preliminary results and future directions. International Journal of Methods in Psychiatric Research 1995; 5: 139–151.

- The majority of persons with co-occurring substance-related and mental health disorders receive no treatment.[20]

- For those who **have** been treated, often one problem is diagnosed while the other is missed. **Cocaine abuse** may be known, but **attention deficit disorder** with hyperactivity may be missed. **Schizophrenia** may be diagnosed, but frequent **marijuana use** may be unsuspected or considered insignificant.

- Most of those who have been treated for **both** disorders have had to go to two offices: one for substance abuse and another for mental health treatment. In addition to the inconvenience, **coordination of treatment plans is the exception,** not the rule.

SAMHSA is the Federal agency with the most direct responsibility for the welfare of those with co-occurring disorders. Responding to this responsibility, SAMHSA convened 141 expert consultants and staff on November 13 and 14, 1995, to begin the development of a national strategy to improve prevention and treatment for persons with co-occurring substance-related and mental health disorders.

The consultants worked in seven tracks, focusing on the following subject areas: **Data and Research; Children and Adolescents; Best Prevention and Treatment Practices; Education and Training; Homelessness; Criminal Justice; and Financing and Managed Care.**

The tracks were asked to develop recommendations for the National Strategy. The track on homelessness and criminal justice divided itself into two; the result was seven sets of track recommendations. The recommendations were then reorganized into this National Strategy.

The **National Strategy** is designed around four broad **goals:**

Goal I: Data and Research
Goal II: Best Prevention and Treatment Practices
Goal III: Education and Training
Goal IV: Financing and Managed Care

The recommendations of the three tracks concerned with specific subpopulations—children and adolescents, homeless persons, and those in the criminal justice system—are woven throughout this document because they intersect in significant ways with each of the issue goals.

There are 3 to 5 Objectives for each of the 4 Goals, for a total of 17 Objectives. There are between 1 and 11 Strategies for each Objective, for a total of 83 Strategies in the overall recommended National Strategy.

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[20]Osher, F.C., Drake, R.E. Reversing a history of unmet needs: Approaches to care for persons with co-occurring addictive and mental disorders. American Journal of Orthopsychiatry 1996; 66(1): 4–11.

The Mission Statement of the National Strategy

To improve prevention, treatment, and rehabilitation services for the several million individuals with, or at risk of developing, co-occurring substance-related and mental health disorders. Certain vulnerable subpopulations, including children, homeless persons, and those in the juvenile and adult justice systems, require particular attention; untreated disorders in these subgroups may disproportionately increase risks and costs for all citizens.

The Vision Statement of the National Strategy

A nationwide behavioral health care system that provides integrated, cost-effective, high quality substance-related and mental health services for people with, or at risk of developing, co-occurring disorders. By integrating treatment with support for meeting other basic human needs, the health status as well as the economic and social well-being of these individuals can be enhanced.

SAMHSA's Commitment to Action

Two key initiating action steps that would demonstrate SAMHSA's determination to propel the National Strategy forward were recommended by the conferees:

1. **SAMHSA was urged to create a unit responsible for integrated co-morbidity services and monitoring the progress of the National Strategy. This step has been taken.** SAMHSA has recently created a team responsible for supporting the implementation of the National Strategy. The establishment of this team acknowledges and legitimatizes the population of individuals with co-occurring disorders.

2. **SAMHSA was urged to reconvene the expert panel,** to meet with other agencies, members of Congress and other public officials, and representatives of the public, including representatives of family, consumer, and professional organizations.

The reconvening will seek to assure that other agencies accept responsibility for the parts of the National Strategy that fall within their jurisdiction or areas of concern. The National Strategy is intended to be a widely shared and supported effort, initiated by SAMHSA but carried out by many.

Goal I: Data and Research

To gather, generate, synthesize, analyze, and disseminate the best possible data and information about the causes, incidence, prevalence, course, and consequences of co-occurring disorders in the U.S. population.

Objective I-A: Determine what we need to know and create a standardized matrix into which gathered information can be sorted.

Strategies: 1. **Uniform definitions and a data matrix should be developed.** SAMHSA and The National Institute of Mental Health (NIMH) should initiate this effort, in collaboration with other agencies within the Department of Health and Human Services (DHHS); with other Federal alcohol, drug abuse, and mental health agencies; and with non-Federal agencies.

2. Alternatively, a **single entity** such as the Institute of Medicine (IOM) could be contracted with to identify information gaps and guide development of the data matrix and generation of the data standards. An entity such as the IOM could convene experts from selected Federal and non-Federal agencies, manage the process, and produce recommendations for Federal and non-Federal use.

Objective I-B: Organize existing data on co-morbid populations systematically into the matrix created in Objective A; support the research necessary to fill the gaps in information.

Strategies: 1. Administrators and researchers from NIMH, The National Institute of Drug Abuse (NIDA), The National Institute of Alcohol Abuse and Alcoholism (NIAAA), and SAMHSA should **establish a joint research agenda** on effective prevention, treatment, and services research on co-occurring disorders. The limited demonstration resources of these agencies can be maximized by jointly funding significant research projects.

2. SAMHSA should provide direction in the **standardized collection of data** about access, treatment, relapse, and other outcome measures.

3. All Federal agencies should encourage and support **longitudinal data collection.**

4. Client **data** should be **linked across systems,** with full regard for confidentiality and informed consent. SAMHSA should support this effort.

5. HHS and The National Institutes of Health (NIH) should establish **standards** for research grants that require grantees **to collect relevant information on co-occurring disorders.**

6. All Federally funded grants should ensure that assessment instruments and studies **reflect cultural diversity.** The protection of human subjects must be respected.

7. Training for State agency personnel regarding data collection and analysis should be supported. SAMHSA should encourage and assist with such training.

8. **Co-morbidity surveys of the juvenile justice and the adult criminal justice populations** should be conducted. SAMHSA and the Department of Justice should collaborate on these projects.

9. Grants for criminal justice populations should require the collection of uniform data on co-morbidity.

10. SAMHSA staff should support and encourage collaboration among agencies that maintain and generate **data sets on children** with co-occurring disorders. Collaborative efforts to **improve assessment** instruments are critical.

11. SAMHSA should participate in NIMH's current **Epidemiologic Catchment Area Study of children.** The study should, ideally, include children and adolescents in the juvenile justice system.

12. The data system to be established should create **separate data sets** for vulnerable populations, including **children, those in the criminal justice system, and the homeless.**

Objective I-C: Establish and maintain an ongoing data-gathering system to meet the evolving need for information on the co-occurring disorder population, including those who are not receiving treatment. Collected data should provide information on the costs, effectiveness, and outcomes of prevention and treatment services.

Strategies: 1. An entity should be established to assist in the ongoing **collection, analysis, and dissemination** of data on co-occurring disorders. Such an entity could provide leadership to other Federal agencies. It could also create compatible data sets for **specific age bands** of persons with co-occurring disorders, such as children and adolescents, young adults, adults, and the older population. This strategy would be enhanced by support from SAMHSA and NIMH.

2. **Longitudinal studies** are needed to assess the **outcomes and costs** of traditional and alternative prevention and treatment services. Such studies should compare the costs and outcomes of: a) no treatment; b) treatment as usual; c) integrated, comprehensive treatment.

3. Data on **Medicare and Medicaid**-funded programs must be gathered on an ongoing basis, as the kinds of services covered by these programs evolve, within managed care and other financing and delivery models.

4. The development of systems to **monitor indirect costs and quality of life outcomes** is critical. Such systems should collect data on the secondary costs associated with the treatment and support of those with co-occurring disorders; these costs would include those borne by general health, housing, criminal justice, and social service agencies.

Objective I-D: Assure the continuous dissemination of data and information on co-occurring disorders to clinicians, clients, families, decision makers, and to the public at large.

Strategies: 1. SAMHSA and NIMH should establish an **ongoing consortium on co-morbidity** data that meets on a regular basis and disseminates its reports widely.

2. SAMHSA and NIH should focus their **public information initiatives,** including their publications, conferences, technical assistance, and speakers bureaus, on **co-occurring disorders.**

3. SAMHSA should maintain and, where necessary, expand its **technical assistance** capability to agencies that seek to improve data systems.

4. The use of new and improving technologies, such as the World Wide Web and Consumer Health Informatics, should be supported in order to disseminate information about co-occurring disorders to expanding professional and non-professional audiences. SAMHSA, via its Center for Mental Health Services, is setting an example by establishing **KEN, the Knowledge Exchange Network.**

Goal II: Best Prevention and Treatment Practices

To increase the percentage of individuals with or at risk of developing co-occurring disorders who receive cost-efficient, comprehensive, integrated services.

The experts assigned to the Prevention and Treatment Track emphasized that **co-occurring substance-related and mental health disorders are preventable and treatable.** There was consensus that early, assertive intervention directed at newly developed *single* disorders might prevent the development of *co-occurring* disorders. There was also consensus that **integrated treatment**—the simultaneous attention to all disorders by appropriately skilled and experienced treatment professionals—**is the most effective approach currently available for treating co-occurring disorders.**

The panel also recognized that persons with co-occurring disorders have needs in other life domains that must be addressed if treatment is to be successful. These include safe, affordable, and adequate housing; adequate income; vocational training; treatment for their multiple health disorders; and strong support networks.

Objective II-A: Identify and implement best prevention practices.

Strategies: 1. A national strategy on **prevention,** focused specifically on **antecedents** of co-occurring disorders, should be developed. This strategy would include early detection, education, and the provision of services for those at high risk of developing co-occurring disorders (e.g., children with learning disorders; persons experiencing trauma, including child or domestic abuse; persons with predisposing family conditions; etc.). SAMHSA should initiate the development of this **national strategy on prevention.**

2. **Prevention** programs should be designed along a **continuum,** addressing **primary, secondary, and tertiary** prevention in accord with established public health principles. Prevention programs should be based on data that demonstrate effectiveness.

3. Service providers should incorporate substance-related disorders prevention and education efforts in all service programs. Such activities must address the need to reduce **stigma** associated with receiving treatment for mental and substance-related disorders.

4. **Substance-related disorders prevention** should be promoted as a key strategy for the prevention of co-occurring disorders.

5. Assessments should include **family histories,** since relatives with co-occurring disorders are risk markers.

6. Within the **general health care system,** efforts must be made to identify and appropriately **refer** individuals with **co-occurring disorders.** Undiagnosed and untreated substance-related and mental health disorders lead to poor medical treatment outcomes, and contribute to higher health care costs.

Objective II-B: Identify and implement best treatment practices.

Strategies: 1. SAMHSA should collect and disseminate information about successful integrated model programs.

2. The delivery of mental health and substance-related treatment and rehabilitation should be **reorganized to provide integrated services** that are responsive to the unique, complex interactivity of co-occurring disorders.

3. Treatment programs should be designed with a **longitudinal perspective** that works across stages of **treatment, relapse, and recovery.** Program designs should respect the nonlinear nature of treatment and recovery; they should recognize that relapse, an inherent characteristic of chronic, episodic disorders, is an expected feature of the dynamic of recovery from serious mental and substance-related disorders.

4. **Assertive case management** should be recognized as an often essential strategy in treating co-occurring disorders.

5. All agencies should seek to develop **comprehensive diagnostic protocols** that are sufficiently refined to permit detection of co-occurring disorders and the **differential patterns of association** between these disorders. This effort should be supported by SAMHSA and NIMH.

6. **Program certification** and licensure at the State and local level should be **redesigned** to permit and encourage **integrated treatment.**

7. **Professional staff** (including substance abuse counselors, physicians, nurses, social workers, mental health counselors, psychologists, etc.) should be trained to assess, diagnose, and treat co-occurring disorders. They should also be trained to provide rehabilitative services.

8. A **service provision design** focusing on **children** with co-occurring disorders is needed. SAMHSA should act as the **catalyst** for the initiation of the design.

Objective II-C: Assure cost-effective treatment practices.

Strategies: 1. Programs should recognize and respond to the **reciprocal interaction between substance-related and mental health disorders.** Treating only one disorder may be ineffective, resulting in increased costs.

2. Comparisons of the costs of treatment versus nontreatment should be viewed broadly and longitudinally. The comparisons should factor in the impact of treatment accompanied by rehabilitation on total costs.

3. Co-occurring substance-related and mental health disorders are **interdependent.** Treatment and rehabilitation for co-occurring disorders generally requires a **more complex treatment plan,** carried out over a **longer** period of time.

Objective II-D: Focus on target populations: child and adolescent, criminal justice, homeless.

Strategies: 1. Prevention and treatment should be relevant and sensitive to **culture, ethnicity, and gender.**

2. **Culturally relevant** instruments for screening, assessment, diagnosis, tracking, and followup must be developed.

3. **Treatment gaps** for persons with co-occurring disorders in the **criminal justice system** should be identified; the development of additional services for individuals in the criminal justice system should be supported.

4. Treatment services to vulnerable populations such as children and the homeless must include work with families, a focus on **health** problems including **HIV-AIDS,** attention to **rehabilitation,** and **social support.**

5. Providers and payors must recognize that a percentage of target population clients will require an **intensive** level of treatment and rehabilitation services for an **extended** period.

Objective II-E: Integrate prevention, treatment and rehabilitation of co-occurring disorders with existing and newly created comprehensive human service and education systems.

Strategies: 1. Programs at the State level should **stimulate** coordination between mental health and substance abuse treatment programs by including specific **performance objectives** in performance partnerships/block grants.

2. Strong **linkages** should be forged between SAMHSA and agencies serving the criminal justice population.

Goal III: Education and Training

To equip a committed workforce of adequate size with the knowledge, skills, abilities, and motivation needed to treat individuals with co-occurring disorders.

Objective III-A: Upgrade the qualifications of current mental health and substance-related disorders practitioners through the provision of additional education and training, including cross-training, to enable them to provide integrated treatment.

Strategies: 1. SAMHSA should coordinate Federal efforts to help agencies carry out this objective. Such assistance could take the form of expert faculty, **technical assistance, courses** for agencies, and **workshops** at professional conferences.

2. **Incentives** to attend education and training should be provided by the employing agency, with the encouragement and support of SAMHSA.

3. **Pilot cross-training** projects should be encouraged and supported by SAMHSA.

4. **Standards** for credentialing mental health and substance-related disorders staff should be modified to require training in the **integrated treatment** of co-occurring disorders.

5. SAMHSA should provide training on its nonprofit **service/housing delivery model** to States and localities.

6. **Jail, prison, probation, and parole** programs should provide cross-training for their mental health and substance abuse treatment staffs.

7. **Rural practitioners** should receive special training to ensure that they have the range of skills needed to diagnose, treat, and rehabilitate those with co-occurring disorders.

8. All training and technical assistance programs should be **sensitive to cultural, ethnic, and gender differences.**

Objective III-B: Provide integrated education to those now in training.

Strategies: 1. SAMHSA should support the development and distribution of **model curricula** for mental health and substance-related disorders professional schools.

2. SAMHSA should support the detailed listing of the **core competencies** required of those who treat co-occurring disorders.

3. SAMHSA should support the development of **postdegree certification** programs to encourage advanced cross-training.

Objective III-C: Upgrade the present faculty: train the trainers.

Strategies: 1. Faculty who are skilled in teaching the integrated treatment of co-occurring disorders should take on leadership roles in developing **curricula for their mental health or substance abuse training** schools. Such curricula should be freely exchanged among schools.

2. SAMHSA should coordinate the development of an identified **critical mass of faculty and practitioners** who are skilled in the treatment of co-occurring disorders. This group would provide innovative training to others, thus increasing the rate of knowledge dissemination.

3. **Incentives** should be offered to encourage faculty to **develop and use new training modules** for integrated treatment.

Goal IV: Financing and Managed Care

Within currently available resources, ensure that funds are allocated in financially accountable ways to maximize effective treatment, recovery, and rehabilitative services to individuals with co-occurring disorders.

Objective IV-A: Identify current streams and patterns of funding for prevention and treatment of co-occurring disorders. The Health Care Financing Agency (HCFA) of the Department of Health and Human Services could coordinate this initiative with SAMHSA.

Strategies: 1. An **accounting of current expenditures** on prevention and treatment of co-occurring disorders, including costs shifted to welfare, criminal justice, housing, health care, **should be developed.**

2. **Cost benchmarks** that can measure the amount of funding necessary to ensure the provision of adequate services should be established.

3. A **common method for cost accounting** based on the Center for Substance Abuse Treatment's (CSAT's) initiative on unit costs should be designed.

Objective IV-B: Encourage reallocation of separate funding streams to increase the integration of treatment and rehabilitation for co-occurring disorders.

Strategies: 1. The Federal government should establish an **incentive pool** for States and localities **to encourage the use of integrated planning for homeless populations** with co-occurring disorders. Integrated planning should address not only treatment for mental health and substance-related disorders in the homeless, but also their housing, income, and other needs. Any States that develop and implement an integrated services approach should be subject to fewer categorical block grant restrictions.

2. State contracts should be required, as a **core objective,** to integrate services for persons with co-occurring disorders.

3. The **blending of split sources of funds** in the public and private sector should be encouraged.

Objective IV-C: Encourage the development of new, flexible, and blended funding, as well as other resources, to expand prevention and treatment of co-occurring disorders.

Strategies: 1. The following sources of funds should be investigated:

Categorical mental health and substance abuse funds
Block grant funds
Criminal justice system funds
Department of Veterans Affairs funds
Drug asset forfeiture funds
Special Housing and Urban Development funds
Tobacco and liquor taxes
Education funds
Tax incentives for corporations that provide model health benefits

Objective IV-D: Propose a model managed care funding mechanism for the prevention and treatment of co-occurring disorders.

Strategies: 1. Managed care systems that provide **integrated funding** for treatment of co-occurring disorders should be promoted.

2. **Basic capitation rates** for individuals with co-occurring disorders should be established.

3. **Special risk adjustments** should be developed to ensure the adequacy of funds **for treatment and rehabilitation of the most seriously ill.**

4. **Excessive premiums** and other **matters of concern to small businesses** should be addressed.

5. **Standards should be established for contracts** that fund prevention, treatment, and rehabilitation of co-occurring disorders. The standards should encourage integrated programs that define expected outcomes and evaluate program effectiveness.

6. Standards that ensure the **adequacy of children's services** should be **developed and maintained.**

7. **Wraparound** and supportive services should be encouraged.

8. Funds for **family support and education** should be provided.

9. **Adequate numbers of staff who are cross-trained** in the provision of integrated treatment and rehabilitation should be ensured.

10. **Consumers** should be educated to better understand and use **managed care options.**

11. **Consumers should be actively involved** in the design of managed care benefits and service systems.

Objective IV-E: Propose guidelines for holding managed care organizations accountable for ensuring access to prevention, treatment, and rehabilitation services for co-occurring disorders.

Strategies: 1. **Federal standards for managed care organizations,** including a requirement for a minimum set of integrated services, should be developed.

2. **Efforts should be undertaken to monitor the adequacy of Medicare and Medicaid funding.**

3. Standards should be established that limit the percentage of funds allocated for **administration and profit** in managed care plans.

4. Both **prevention** and treatment services must be offered.

5. The impact of various **gatekeeper** mechanisms on access to treatment should be studied.

6. Governmental mandates to prevent **involuntary disenrollment** should be supported.

7. An adequate and time-sensitive **grievance and appeals process** should be established.

8. **Report cards** should be developed for prevention, treatment, and rehabilitation based on acceptable minimum and optimum performance standards.

9. **Expenditures designed to prevent** the subsequent development of co-occurring disorders should be encouraged and monitored.

Introduction

The background of this Conference Report and Recommended National Strategy

In 1992, SAMHSA was created by congressional action and presidential signature. It assumed some of the functions of the former Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), while others were assigned to the National Institutes of Health.

When ADAMHA was terminated by legislative action, the research arms of the National Institutes of Mental Health, Drug Abuse, and Alcohol Abuse and Alcoholism were moved to the National Institutes of Health. The former Office of Substance Abuse Prevention (OSAP) became the new Center for Substance Abuse Prevention (CSAP), within SAMHSA. The former Office for Treatment Improvement became the new Center for Substance Abuse Treatment (CSAT), within SAMHSA. The services portion of the National Institute of Mental Health (NIMH) became the new Center for Mental Health Services (CMHS), and became SAMHSA's third center.

As a result of the above changes, since 1992 SAMHSA has administered and coordinated the efforts of CSAT, CSAP, and CMHS. SAMHSA was legally authorized, by legislative enactment, to oversee strategies for improving services for persons with co-occurring substance abuse and mental health disorders. This report is a response to that authorization.

SAMHSA's First Action: The Conference

The advantages of bringing together an expert panel were seen early on, and by 1993, plans were being developed to seek advice from experts. Dr. Nelba Chavez, the Administrator, assigned key staff the task of coordinating the conference effort. Each of the three centers within SAMHSA provided staff support. Dr. Bert Pepper, an expert whose knowledge of the field of co-occurring disorders is widely respected, was engaged to be the technical consultant. Dr. Pepper was asked to prepare background technical materials for the conference, chair the plenary sessions, and prepare the final report.

Three preliminary planning meetings were held in 1994 and 1995, and resources were secured to hold the conference on November 13 and 14, 1995, at the Georgetown University Conference Center in Washington, DC. One hundred forty one consultants and staff, divided into six (and later, seven) working tracks, were convened on Monday morning by the SAMHSA Administrator and the technical consultant. Each track was led by a member of the SAMHSA Advisory Council and assisted by a co-chair and a staff member who served as recorder for the track. The charge to the tracks, offered at a plenary session, was to offer their best opinions and advice on the issue at hand, and to provide recommendations that could form the core of a National Strategy for improving services for individuals with co-occurring disorders. The consultants then separated into the working track groups. They entered into their tasks with great energy and enthusiasm.

A crisis arose by the middle of the first day of the conference. A fiscal shutdown of the Federal Government was announced, to begin on the morning of November 14, 1995, the second and last day of the conference. At that point the staff and the experts, many of whom had traveled far to come to the Nation's capitol and lend their expertise, rallied and rearranged the schedules for both plenary and track sessions so that as much of the vital work of the conference as possible might be completed before the Government shutdown. It was the joint work of experts and staff, and their strong commitment to the issue, that led to the successful completion of the conference. The conference presentations and reports of the track deliberations have provided the raw materials for this conference report and policy document. The draft report was subsequently reviewed by representatives of each track, SAMHSA staff, and selected expert reviewers in the field; they are credited in appendix D.

Why Is a National Strategy Necessary?

The number of persons with co-occurring substance-related and mental health disorders exploded into the millions by the 1980s. We cannot be certain that they did not exist by the millions in earlier decades, because the first meaningful quantitative research that counted them was the **Epidemiologic Catchment Area** study of the 1980s. Every survey done over the past 10 years, including the *National Co-morbidity Survey* of 1992, has indicated that most members of this population receive inadequate, ineffective, or no treatment services. The cost to the individuals, their families, and the Nation is enormous. In addition to the direct health consequences, there are the direct costs of treating, housing, and providing financial support for the number who are unable to work and support themselves because of their disorders. In addition, there are the indirect costs of sheltering those who are homeless, and funding the sector of the criminal justice system that deals with them. And, there is the cost of lost productivity.

A national strategy for improving services to millions of persons with co-occurring substance-related and mental health disorders has been needed for some time; current changes in health care funding. organization, and delivery have increased the need to a critical level. In the past 2 years, the leadership role for reorganizing the health care delivery system has shifted from the Federal Government to a shared role with others: with the States for publicly funded care, and with the private sector for those whose care is privately insured and funded.

All health funding systems are moving toward some model of managed care, and capitated funding is emerging as a way to shift the responsibility for cost management and containment to providers. The consequences of this shift cannot be predicted with any certainty. Many experts foresee risks for those most in need of multiple, expensive, and long-term services, such as individuals with co-occurring substance-related and mental health disorders. Payors who have not served such individuals in the past will need to learn about them, and adapt the services they are accustomed to providing. This may prove to be clinically difficult and costly.

Because the Federal attempt to provide overall leadership for health care reform—the Clinton health plan—was not adopted by the Congress, the Federal role has necessarily moved to advocating for positive partial solutions, and to a watchdog role—attempting to ensure that populations in need are protected from harm. Of course, the Federal Government remains a major payor-purchaser of health care, and changes in Medicaid and Medicare must be guided in such a way as to minimize negative effects on individuals with co-occurring substance-related and mental health disorders.

The treatment needs of persons with co-occurring substance-related and mental health disorders are multiple and complex. But their needs go beyond the clinical; they include sensitivity to racial, ethnic, cultural and language issues; housing for the homeless; health care for medical conditions; financial supports; and legal assistance for those involved with the police and courts. Only by building consensus on achievable, measurable outcomes can we develop a national strategy that will gain support from the public, the professions, and government leaders.

Heretofore, prevention services specific to the co-morbid population have not received much attention. However, new information about age of onset of mental disorders and age of onset of substance-related disorders, found in the NCS, calls attention to the role that prevention services may play in stemming the onset of co-occurring substance-related and mental health disorders.

On a positive note, times of innovation and crisis always present opportunities for progressive changes, if individuals who share a vision, determination, and a consensus about needed action are prepared to act. SAMHSA, through the activities initiated by this conference, intends to organize and lead such an effort.

Chapter I: The Key Question

Why have the prevention and treatment needs of a majority of the 9 or 10 million individuals who have both a substance-related and a mental health disorder not been met?

In seeking an answer to this question, a list of the **usual**—but certainly not universal—predicaments troubling individuals with co-occurring substance-related and mental health disorders emerges:

- **The reasons** for distressing symptoms and troubling behaviors are not understood by self, family, friends, counselors, therapists, or community.[21]

- **It is common** for a child or adolescent who is experiencing the symptoms of their first disorder to receive no treatment if the behavior is not dangerous or disruptive.[22] The first symptoms are likely to be mental, especially anxiety or depression.[23] In succeeding years the adolescent may deal with these troubling feelings by the use of alcohol or other drugs, and this may support the development of the second disorder.

- **Recognition** of both mental and addictive disorders in one person is often problematic. The individuals—and those who know them—certainly are aware that something is wrong. But what is wrong is usually identified as a single problem, like alcoholism, not a dual problem, like alcoholism and depression. Or, cocaine abuse is known but not the co-occurring persistent attention deficit disorder. Or, schizophrenia is known, but not the heavy, daily marijuana use.[24]

- **For the majority,** no treatment has been provided by a mental health or substance abuse clinician. Most treatment, when it is offered, is in the general health and social services sector.[25] Perhaps a family doctor has prescribed a low dose of an antidepressant or a benzodiazepine for anxiety. Benzodiazepines are almost always contraindicated in the presence of a substance abuse disorder.

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[21]Green, V.L. The resurrection and the life. American Journal of Orthopsychiatry 1996; 66(1): 12–16.

[22]Greenbaum, P.E., Foster-Johnson, L., Petrila, A. Co-occurring addictive and mental disorders among adolescents: Prevalence research and future directions. American Journal of Orthopsychiatry 1996; 66(1): 52–60.

[23]Kessler, R., Nelson, C., McGonagle, K. The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. American Journal of Orthopsychiatry 1996; 66: 17–31.

[24]Miller, N.S. Issues in the diagnosis and treatment of comorbid addictive and other psychiatric disorders. Directions in Psychiatry 1994; 14(25): 1–8.

Lehman, A.F. Heterogeneity of person and place: Assessing co-occurring addictive and mental disorders. American Journal of Orthopsychiatry 1996; 66(1): 32–41.

[25]Manderscheid, R.W., Rae, D.S., Narrow, W.E., Locke, B.Z., Regier, D.A. Congruence of service utilization estimates from the Epidemiologic Catchment Area Project and other sources. Archives of General Psychiatry 1993; 50: 108–114.

Narrow, W.E., Regier, D.A., Rae, D.S., Manderscheid, R.W., Locke, B.Z. Use of services by persons with mental and addictive disorders 1993. Archives of General Psychiatry 1993; 50: 95–107.

Kessler, R., McGonagle, K. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Archives of General Psychiatry 1994; 51: 8–18.

- **For those** who have been treated by a substance abuse or mental health specialist, the second diagnosis has not been made.[26] Or, if made, the second diagnosis has not been noted in the chart and treated, for fear of a problem with reimbursement or agency exclusion rules.

- **For those** who have had treatment for both their substance-related and their mental health disorder, most have had to go to two offices or agencies and have been sent back and forth:[27] "We'll help you with your depression when you've been sober for 6 months," or, "We'll be happy to enroll you in our alcoholism counseling program when you have had 6 months free of suicide attempts and are off medication."

- **Researchers agree**[28] that it is unusual for an individual with co-occurring disorders to be diagnosed promptly and correctly and to receive simultaneous or sequenced treatment by one clinician trained to treat both substance-related and mental health disorders, or by a unified mental health and substance abuse team. Yet it is the consensus of these same experts that integrated treatment is the preferred treatment response to co-occurring disorders.

To understand why the situation described above exists in 1996 it is necessary to review the history of substance-related and mental health disorders and their treatment in the United States. This section of the report is designed to provide brief answers to the questions of when and how the problem of co-occurring disorders developed.

DSM-IV:[29] From a New Diagnostic Tool, to New Views of Co-Occurring Disorders

Psychiatric and substance-related disorders diagnosis has advanced rapidly since 1980, when the *Diagnostic and Statistical Manual, Third Edition* (DSM-III) was published by the American Psychiatric Association. DSM-III has subsequently undergone two revisions: DSM-IV, the current version, is widely accepted in the United States by treatment programs, government agencies, payors, and managed care companies.

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[26]Green, V.L, The resurrection and the life. American Journal of Orthopsychiatry 1996; 66(1): 12–16.
[27]Drake, R.E., Mueser, K.T., Clark, R.E., Wallach, M.A. The course, treatment, and outcome of substance disorder in persons with severe mental illness. American Journal of Orthopsychiatry 1996; 66(1): 42–51.
[28]Greenbaum, P.E., Foster-Johnson, L., Petrila, A. Co-occurring addictive and mental disorders among adolescents: Prevalence research and future directions. American Journal of Orthopsychiatry 1996; 66(1): 52–60.
Osher, F.C., Drake, R.E. Reversing a history of unmet needs: Approaches to care for persons with co-occurring addictive and mental disorders. American Journal of Orthopsychiatry 1996; 66(1): 4–11.
Green, V.L. The resurrection and the life. American Journal of Orthopsychiatry 1996; 66(1): 12–16.
Lehman, A.F. Heterogeneity of person and place: Assessing co-occurring addictive and mental disorders. American Journal of Orthopsychiatry 1996; 66(1): 32–41.
Alexander, M. Women with co-occurring addictive and mental disorders: An emerging profile of vulnerability. American Journal of Orthopsychiatry 1996; 66(1): 61–70.
Drake, R.E., Mueser, K.T., Clark, R.E., Wallach, M.A. The course, treatment, and outcome of substance disorder in persons with severe mental illness. American Journal of Orthopsychiatry 1996; 66(1): 42–51.
[29]DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, fourth edition. Washington, DC: American Psychiatric Association, 1994.

In an effort to increase the reliability of diagnosis of both substance-related and mental health disorders, DSM-IV uses sets of criteria and decision trees. The DSM system has led to greater reliability of diagnosis; this has, in turn, made research into substance-related and mental health disorders easier.

DSM-IV uses a **five-axis system.** There can be multiple diagnoses on each axis:

Axis I is used to diagnose both substance-related and mental health disorders. DSM-II considered substance-related disorders to be manifestations of psychiatric or personality pathology. In contrast, DSM-IV devotes 98 pages of text to substance-related disorders, with criteria for **substance abuse, dependence, intoxication, and withdrawal.** The chapter discusses and offers diagnostic criteria for the following specific substances: alcohol, amphetamines, caffeine, cannabis (marijuana), cocaine, hallucinogens, inhalants, nicotine, opioids, phencyclidine (PCP), sedatives, hypnotics, anxiolytics, and polysubstance-related disorders.

Axis II is used for diagnosing any of 10 specific personality disorders. These are conditions that arise early in life, tend to severely impair the ability of the person to manage social and personal relationships, and may predispose to an Axis I Disorder. For example, *borderline personality disorder*, more commonly diagnosed in women, is commonly associated with alcohol and other drug-related disorders and may also associate with a variety of severe and troubling psychiatric symptoms and disorders. *Antisocial personality disorder*, more commonly diagnosed in men, also commonly co-occurs with substance-related and psychiatric problems.[30]

Axis III lists medical disorders that must be kept in mind when treating the substance-related and/or mental health disorders of the individual.

Axis IV lists stressors that may have caused or worsened the individual's disorders.

Axis V is used to make a global estimate of the functioning of the individual at the time of the diagnostic assessment.

By including all currently recognized alcohol and other substance use and abuse disorders on Axis I, psychiatry now includes substance-related disorders within its area of concern. In the DSM-II, alcohol and drug abuse were considered to be manifestations of a personality disorder or other psychiatric pathology. This classification hindered research into substance-related conditions as primary disorders, and tended to cause co-occurring substance-related and mental health disorders to remain hidden.

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[30]Chiles, J.A., Von Cleve, E., Jemelka, R.P., Trupin, E.W. Substance abuse and psychiatric disorders in prison inmates. Hospital and Community Psychiatry 1990; 41: 1132–1134.
Regier, D.A., Farmer, M.E., Rae, D., Locke, B.Z., Keith, S.J., Judd, L.L., Goodwin, F.K. Comorbidity of mental disorders with alcohol and other drug abuse. Journal of American Medical Association 1990; 246(19): 2511–2518.

The Search for Co-Occurring Relationships

The placement of substance-related disorders with mental health disorders on Axis I of DSM-IV has led to a renewed search for the **relationship** between these disorders. The phrase, **co-occurring substance-related and mental health disorders,** used in this report, arises from this search. It refers to **the person who meets DSM-IV criteria for one or more mental health disorders *and* for one or more substance-related disorders.**

Some State administrative agencies do not consider personality disorders to be mental health disorders for purposes of eligibility for funded treatment. They may limit their definition of co-occurring disorders to individuals with a major mental illness such as schizophrenia **and** substance abuse or dependence. However, most clinicians find that individuals with personality disorders are difficult to treat and in great need of treatment.

Clinicians who do a comprehensive diagnostic assessment may diagnose as many as five or more disorders: one or more mental disorders, a personality disorder, and abuse of or dependence on two or three substances. It is for this reason that the terms **"co-occurring disorders"** and **"co-morbidity"** are often more accurate than the term **"dual disorders."**

An historical perspective is needed in order to fully understand the usefulness and significance of the DSM diagnostic system. The following is a very brief history of the treatment of substance-related and mental health disorders in the 20th century in the United States.

Until the 1960s there were sharp distinctions and few interactions between clinicians and programs working with

- individuals with **mental disorders,**
- persons who used illicit **drugs** or abused prescription **drugs,** and
- persons who used excessive amounts of **alcohol.**

The sharp separation between the groups was, and often still is, reflected in the organization of discrete governmental agencies for each of the three groups. This has been, and often still is, true at Federal, State, and local levels.[31] In a parallel manner, most community agencies were created to treat one disorder.

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[31]Hendrickson, E., Schmal, M., Albert, N., Massaro, J. Dual disorder treatment perspectives on the state of the art. Tie-Lines 1994; 11: 1–15.

Key Dates and Landmark Events

- 1935: Alcoholics Anonymous (AA) was founded.
- 1946: The **National Mental Health Act** created the National Institute of Mental Health (NIMH).
- 1953: Narcotics Anonymous (NA) was founded.
- 1960: **The Disease Concept of Alcoholism** was proposed by Jellinek.
- 1963: **The Community Mental Health Centers and Mental Retardation Facilities Act** began a movement to create a network of 2,400 Comprehensive Community Mental Health Centers (CMHC) that were to blanket the country. Each was to have a minimum of five essential services: **24-hour emergency, inpatient, outpatient, consultation and education, and partial hospitalization.**
- 1966: The **Narcotic Addiction Rehabilitation Act** authorized the NIMH to fund therapeutic communities, methadone programs, and community substance abuse treatment.
- Later 1960s: Decriminalization laws redirected addicts from the criminal justice to the health system.
- 1970: The **Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act** funded alcoholism treatment and created the National Institute on Alcohol Abuse and Alcoholism (NIAAA) within NIMH, to support and conduct research, and to administer a formula grant program.
- 1972: The **Drug Office and Treatment Act** created the National Institute on Drug Abuse (NIDA) within NIMH, to support and conduct research, and to administer a formula grant program.
- The **Alcohol, Drug Abuse and Mental Health Administration** (ADAMHA) was established as the parent agency of NIMH, NIAAA, and NIDA.
- 1975: **The Community Mental Health Centers Act Amendments** called upon CMHCs to develop alcoholism and drug abuse services, and to provide services to the seriously and persistently mentally ill.
- 1981: The Reagan administration created a single **block grant** for alcoholism, drug abuse and mental health, with one-third fewer dollars than the formula grants that were being replaced.

- Early 1980s: The Reagan administration **zero-tolerance** policy for drug abuse tended to move addicts back toward the criminal justice system, and away from the health system.

- 1986: The Office for Substance Abuse Prevention (OSAP) was created.

- 1989: The Office of Treatment Improvement (OTI) was created administratively, within ADAMHA.

- 1992: SAMHSA was created, and ADAMHA was terminated. The research arms of NIMH, NIDA and NIAAA were moved from ADAMHA to the **National Institutes of Health.** OSAP became The Center for Substance Abuse Prevention (CSAP). OTI became The Center for Substance Abuse Treatment (CSAT). The services programs of NIMH became The Center for Mental Health Services (CMHS).

- 1992: SAMHSA, composed of CSAT, CSAP, and the CMHS, was legally authorized to oversee strategies to serve persons with co-occurring substance-related and mental health disorders.

- 1994: The Social Security Independence and Program Improvements Act was enacted, limiting Social Security benefits to 36 months if disability is **in any part** due to a substance use disorder.

From the 1960s to the 1990s

Until the late 1960s, when deinstitutionalization (a State-by-State policy of reducing the size of State hospitals by limiting admissions and discharging long-stay patients) began, seriously mentally ill individuals had little opportunity to use drugs, because they spent most of their lives in hospitals. Deinstitutionalization—the dramatic reduction of the State hospital bed complement—has changed that situation. In 1955, when the population of the United States stood at 170 million,[32] the census of our State and county psychiatric hospitals stood at **559,000.** In 1992, with a population estimated at 270 million, we had **92,000** State hospital beds.[33] Most mentally ill people now live in communities, but many are concentrated in the juvenile and adult criminal justice system and its institutions.

The U.S. Department of Justice reported that as of June 1994, there were over **1 million** individuals in State and Federal prisons, and about **500,000** in local jails.[34] Other data indicate that high percentages of inmates have co-occurring substance-related and mental health disorders.[35] Although it was unintended, the manner in which

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[32]U.S. Census Bureau, annual U.S. census summary.
[33]Regier, D.A. Epidemiology, in Kaplan and Sadock, Comprehensive Textbook of Psychiatry 1992; 390–392.
[34]Holmes, S.A. The New York Times, 10/28/94; p. 1.
[35]Regier, D.A., Farmer, M.E., Rae, D., Locke, B.Z., Keith, S.J., Judd, L.L., Goodwin, F.K. Comorbidity of mental disorders with alcohol and other drug abuse. Journal of American Medical Association 1990; 246(19): 2511–2518. Chiles, J.A., Von Cleve, E., Jemelka, R.P., Trupin, E.W. Substance abuse and psychiatric disorders in prison inmates. Hospital and Community Psychiatry 1990; 41(10): 1132–1134.

deinstitutionalization was carried out apparently contributed to **transinstitutionalization,** from State and county mental hospitals to jails and prisons.

Substance use and abuse has changed in the past 30 years, as has our body of knowledge. In the 1967 edition of the *Comprehensive Textbook of Psychiatry*, edited by Freedman and Kaplan, there were 1628 text pages, of which 38, or 2%, were devoted to all substance-related disorders. The 38 pages comprise one chapter: "Personality Disorders, Sociopathic Type: The Addictions." That chapter estimated that there were 4.5 to 5 million alcoholic persons in the United States at that time; that there were fewer than 50,000 opioid addicts. With regard to non-narcotic addictive disorders, the chapter simply states: "The occurrence and distribution of this condition are not known."

As the problems of substance-related disorders has grown, so has professional interest in their epidemiology, diagnosis and treatment. For example, the DSM-IV has 662 text pages, of which 98, or 15%, are devoted to substance-related disorders.

A 1995 article draws from the data of the National Co-morbidity Survey (NCS)[36] on respondents to the 1992 household survey, aged 15–54. Fifty-one percent had used an illicit substance or abused a prescribed medication in their lifetime, and 15.4% had done so in the past year. Another NCS article looks at the more serious issue of lifetime substance **dependence.**[37] Fourteen percent had been dependent on alcohol at some time in their life, and 7.5% had been dependent on an illicit substance, an abused prescription medication, or an inhalant.

Throughout the history (1975 to the present) of NIDA's annual High School Student Survey the amount of alcohol abuse has not changed greatly, while the use of other drugs, such as cocaine and marijuana, has increased and decreased during this period.[38] In addition, since the 1960s there has been a trend away from the use of alcohol or a single illicit drug of choice: multiple substance use or abuse is now the usual pattern for most individuals, especially for younger persons.[39]

New Conditions, New Observations, and New Terms

In the late 1970s, papers about "the new chronic patient"[40] began to be presented at psychiatric conferences. These individuals were often referred to as "revolving-door patients" and "treatment resistant" because of their frequent admissions to and rapid

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[36]Warner, L.A., Kessler, R.C., Hughes, M., Anthony, J.C., Nelson, C.B. Prevalence and correlates of drug use and dependence in the United States. Archives of General Psychiatry 1995; 52: 219–229.
[37]Anthony, J.C., Warner, L.A., Kessler, R.C. Comparative epidemiology of dependence on tobacco, alcohol, controlled substances, and inhalants. Experimental and Clinical Psychopharmacology 1994; 2: 244–267.
[38]Ciraulo, D.A., Shader, R.I. Clinical Manual of Chemical Dependence. Washington, DC: American Psychiatric Press, 1991; 198–199.
[39]Miller, N.S. Issues in the diagnosis and treatment of comorbid addictive and other psychiatric disorders. Directions in Psychiatry 1994; 14(25): 1–8.
[40]The new young chronic patient [special section]. Hospital and Community Psychiatry 1981; 32(7): 463–481.

discharges from psychiatric hospitals, and failure to follow through with outpatient care recommendations.[41]

In 1980, the term **Young Adult Chronic Patient**[42] was coined and became the name and the focus of the first large national conference about such individuals. The conference keynoted the theme that many adolescents and young adults were being incompletely diagnosed, and therefore unsuccessfully treated in the mental health system. They were becoming chronic, disabled revolving door mental hospital patients because of undiagnosed, untreated, and continuing alcohol or other drug use/abuse (AOD) disorders.

By 1985, the term Young Adult Chronic Patient fell into disfavor, as clients and advocates objected to the word **chronic.** New York and other eastern States began using the term **MICA** (mentally ill chemical abuser), while several western States preferred the term **CAMI** (chemically abusing mentally ill).

About 10 years ago the terms **"dual diagnosis"** and **"dual disorders"** began to be used to refer to the individual with a co-occurring mental health and substance-related disorder. By 1988–89, the terms dual diagnosis and dual disorders[43] had become widely accepted as broad labels for clients with both substance-related and mental health disorders.

In 1994–95 SAMHSA expressed a preference for the term **"co-occurring substance abuse and mental health disorders."**

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[41]Bachrach, L.L. Young adult chronic patients: An analytical review of the literature. Hospital and Community Psychiatry 1982; 33: 189–197.
Pepper, B. Interfaces between criminal behavior, alcohol and other drug abuse, and psychiatric disorders. Center for Substance Abuse Treatment; Treatment Improvement Exchange 1993; Spring: 5–7.

[42]Pepper, B., Kirsher, M., Ryglewicz, H. The young adult chronic patient: Overview of a population. Hospital & Community Psychiatry 1981; 32(7): 463–469.

[43]Minkoff, K., Drake, R.E. Dual Diagnosis of Major Mental Illness and Substance Disorder. New Directions for Mental Health Services, No. 50. San Francisco, CA: Jossey-Bass, 1991.
Evans, K., Sullivan, J.M. Dual Diagnosis: Counseling the Mentally Ill Substance Abuser. New York, Guilford Press, 1990.
Mental and Substance Use Disorders: The Treatment of Dual Diagnosis. A Policy Report for the Washington Metropolitan Region. Washington, DC: Metropolitan Washington Council of Governments, 1995.
Hendrickson, E., Schmal, M., Albert, N., Massaro, J. Dual disorder treatment perspectives on the state of the art. Tie-Lines 1994; X-1-15. XI: 1–15.
Drake, R.E., Osher, F.C., Wallach, M.A. Homelessness and dual diagnosis. American Psychologist 1991; 46(11): 1149–1152.

Modes of Interrelationships Between Disorders

Studies indicate that persons with mental disorders are at least twice as likely to abuse drugs and alcohol as are persons without mental disorders.[44]

Research on treated populations[45] and household surveys indicate that if a person has either a substance-related or a mental health disorder his or her likelihood of developing additional co-occurring disorders is significantly increased. Based on combined projections of the NCS and the Epidemiologic Catchment Area Study, Kessler and Regier[46] estimate that about 10 million U.S. citizens of all ages had co-occurring substance-related and mental health disorders in the year preceding the survey interview. This number includes those in the community, the homeless, and those in institutional settings such as nursing homes, hospitals, and prisons. A substantial number have three or more disorders. More incidence and prevalence data from this study will be presented in chapter II.

There are four possible relationships between two or more co-occurring disorders:

- **One directly causes the other:** For example, there is clinical evidence that the repeated use of cocaine may cause panic attacks, psychotic episodes, and depression, as well as medical disorders such as seizures and strokes.[47]

- **One indirectly leads to the other(s):** For example, social phobia (fear of being with groups of people), panic attacks, or depression may lead to attempts to diminish distress or improve social functioning by the use of alcohol.[48] These are examples of what is commonly referred to as self-medication. In such instances there is a

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[44]Miller, N.S. Issues in the diagnosis and treatment of comorbid addictive and other psychiatric disorders. Directions in Psychiatry 1994; 14(25): 1-8.
Kessler, R. The Epidemiology of Co-Occurring Addictive and Mental Disorders. NCS Working Paper #9. Invited conference paper, presented at the SAMHSA-sponsored conference Improving Services for Individuals with Co-Occurring Substance Abuse and Mental Health Disorders, 11/13/95.
[45]Hesselbrock, M. Meyer, R., Keener, J. Psychopathology in hospitalized alcoholics. Archives of General Psychiatry 1985; 42: 1050–1055.
Osher, F.C., Drake, R.E. Reversing a history of unmet needs: Approaches to care for persons with co-occurring addictive and mental disorders. American Journal of Orthopsychiatry 1996; 66: 4–11.
Ridgely, M.S., Goldman, H.H., Talbott, J.A. Chronic mentally ill young adults with substance abuse problems: A review of relevant literature and creation of a research agenda. Baltimore: University of Maryland School of Medicine, 1986.
Ross, H., Glaser, F., Germanson, T. The prevalence of psychiatric disorders in patients with alcohol and other drug problems. Archives of General Psychiatry 1988; 45: 1023–1031.
[46]Kessler, R. The Epidemiology of Co-Occurring Addictive and Mental Disorders. NCS Working Paper #9. Invited conference paper, presented at the SAMHSA-sponsored conference Improving Services for Individuals with Co-occurring Substance Abuse and Mental Health Disorders, 11/13/95.
[47]Ciraulo, D.A., Shader, R.I. Clinical Manual of Chemical Dependence. Washington, DC: American Psychiatric Press, 1991; 204–209.
[48]Kessler, R. personal communication, 1996.

connection between the two disorders, and treatment of the second disorder is less likely to be successful if the first disorder is not adequately treated.

- **Two or more disorders develop independently from different causes, but impact on each other:** One example might be the development of alcohol abuse in an adolescent who later, largely due to high genetic family loading, independently develops schizophrenia. In such a case, the presence of the alcohol disorder might constitute a stressor or further decrease the individual's compromised coping ability. Even when the two disorders develop independently of each other, they are likely to interact eventually, because they are affecting the personality, emotions, and behavior of the same individual.

- **An independent factor,** such as severe childhood trauma, **might cause both** a mental disorder and a substance-related disorder.

To add to the complexity of this situation, an individual may have three, four, or more disorders; and the relationship between pairs may differ. This is an area that requires additional research. Regier,[49] Kessler,[50] Miller[51] and others have discussed this problem and proposed further studies that may clarify these important relationships.

Organizational Barriers to Integrated Diagnosis and Treatment

Responding to the increase in substance-related problems in the 1960s, the 1970s witnessed efforts to give adequate attention and funding to substance-related research and treatment. Several Federal legislative changes were noted above. In addition, most State governments moved from the pattern of earlier decades—a State department of mental hygiene with a minor subunit for alcoholism and another for drug abuse—to separate agencies for alcoholism and drug abuse. Another impetus for such moves was to gain access to categorical Federal funds. **Utilization review** became a mechanism to limit treatment to **eligible** persons (i.e., those with one, proper disorder).

The formal separation noted above at the governmental level matched the informal separation that was developing simultaneously, as AA, NA, and community alcoholism and drug abuse treatment agencies fought stigma and sought independent recognition and acceptance for their clientele.

The separation of agency funding, licensing, and training eventually led—as cost containment constrained all of them—to competition among the three. Cost containment

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[49]Regier, D.A., Farmer, M.E., Rae, D., Locke, B.Z., Keith, S.J., Judd, L.L., Goodwin, F.K. Comorbidity of mental disorders with alcohol and other drug abuse. Journal of American Medical Association 1990; 246(19): 2511–2518.
[50]Kessler, R. Price, H. Primary prevention of secondary disorders: A proposal and agenda. American Journal of Community Psychology 1993; 21(5): 607–631.
[51]Miller, N.S. Comorbidity of psychiatric and alcohol/drug disorders: Interactions and independent status, Journal of Addictive Diseases 1993; 12(3): 5–16.

strategies included the narrowing of target populations, and separate State and Federal agencies reinforced the separation of clinical, administrative, and financing functions. All of these developments led to the exclusion from treatment of persons with co-occurring disorders, which became commonplace during the 1970s and 1980s.

Training Barriers to Service Integration

Training for alcohol and drug abuse counselors in the 1960s and 1970s grew primarily from the experience and philosophy of AA and NA. The roots were more experiential than academic or scientific, and abstinence was seen as the tool, the method, and the goal. Disagreements with mental health clinicians about the necessity for prescribed medications widened the gap, as many counselors and AA and NA members viewed someone on prescribed medication for a mental disorder as "being on drugs."

A key scientific question, for want of good data, was debated: Were individuals who abused alcohol and other drugs essentially self-medicating underlying psychiatric disorders? Mental health clinicians who believed this to be the case tended to minimize the need for substance abuse treatment, believing that if the mental disorder was treated successfully, drugs would no longer be a problem. Conversely, many substance abuse counselors believed that the psychiatric symptoms were caused by the alcohol and other drugs, and that abstinence, not mental health treatment and medications, was needed for the depression, anxiety, panic, etc., to go away.[52]

Summary

- The problem of co-occurring substance-related and mental health disorders seems to have arisen as an unanticipated byproduct of deinstitutionalization, as well as from other social and economic changes over the past 20 years. It is a relatively new problem, and was not generally recognized until the 1980s.

- The **problems** created by co-occurring substance-related and mental health disorders are easily observed; the individual has obvious difficulties in living and working. However, the **causes** are difficult to define, understand, and treat.

- The simultaneous occurrence of mental health and substance-related disorders poses significant and potentially life-threatening problems for individuals, and multiple challenges for the alcohol, drug abuse and mental services fields.

- Co-occurring substance-related and mental health disorders are associated with a more serious course of illness. Individuals experiencing such disorders are more difficult and more expensive to treat. Their disorders often cause other difficulties: family disruption, unemployment, homelessness, other medical disorders, and criminal justice involvement.

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[52]Gallant, D.M. Alcoholism: A Guide to Diagnosis, Intervention, and Treatment. W.W. Norton, 1987.

- Separate service delivery systems, financing limitations, incompatible treatment philosophies, and providers who are untrained or reluctant to treat both substance-related and mental health disorders in an integrated manner all contribute to the problem.

- There are established interests that have kept co-occurring disorders from being seen and dealt with effectively. To acknowledge the problem and do what is necessary will require many changes, including broadening the training and the treatment activities of the specialty professions.

- An effective National Strategy will need to seek demonstrable, measurable improvement in clinical outcomes. By providing guidance toward specific outcome domains, such as reduced drug use, increased mental health stability, greater housing stability, improved health status, less involvement in the juvenile and adult criminal justice system, a higher quality of life, and higher rates of employment, implementation of the National Strategy will be of maximum value to the Nation.

- An effective National Strategy will also stress achievable and measurable cost savings. These are to be gained through the provision of appropriate, comprehensive, and integrated services that are provided by adequately cross-trained clinicians and/or treatment teams.

Chapter II: Data and Research

Are the problems presented by co-occurring disorders so widespread and prevalent that a major National Strategy initiative is required?

The current focus on co-occurring substance-related and mental health disorders is so new that there has not been adequate research on etiology, best treatment practices (including those for specific populations), or treatment outcomes. The nature of the many interactions between particular pairs, triads, and quartets of disorders is unclear and is the subject of vigorous debate. At present, the results of two major research projects, and several smaller illuminating studies, cast some light on the picture.[53]

The Epidemiologic Catchment Area Study (ECA)[54] and the National Co-morbidity Survey (NCS)[55] represent our state-of-the-art knowledge base for understanding co-occurring substance-related and mental health disorders. Although neither has all the answers needed to form an effective national strategy, the ECA and the NCS can answer some of our basic questions and can suggest approaches to needed additional research and action steps.

The Data

The Epidemiologic Catchment Area Study

The ECA gathered data on institutionalized, noninstitutionalized, and untreated individuals interviewed in household surveys, totaling about 21,000 persons between the ages of 18 and 65. The data were gathered in the early 1980s by the specially trained staffs of five major psychiatric research centers located across the United States. The nature of the data gathering by the five centers prevented the sample from being nationally representative. Data from that survey are still being analyzed and published under the direction of Darrel Regier, M.D., Director, Division of Epidemiology and Services Research of the National Institute of Mental Health. Dr. Regier was a major contributor to the Data Track of the conference, which provided key input for this portion of the report.

The analysis of the ECA provided the first large-scale U.S. data set of persons with mental health and substance-related disorders. The data analysis also illuminated the overlaps and interplay between disorders. Overall, it reported that 23% of those surveyed

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[53]Regier, D.A., Farmer, M.E., Rae, D., Locke, B.Z., Keith, S.J., Judd, L.L., Goodwin, F.K. Comorbidity of mental disorders with alcohol and other drug abuse. Journal of American Medical Association 1990; 246(19): 2511–2518. Kessler, R., Nelson, C., McGonagle, K. The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. American Journal of Orthopsychiatry 1996; 66: 17–31.

[54]Robins, L.N., Regier, D.A. Psychiatric Disorders in America: The Epidemiological Catchment Area Study. New York: Free Press, 1991.

[55]Kessler, R. The Epidemiology of Co-Occurring Addictive and Mental Disorders. NCS Working Paper #9. Invited conference paper, presented at the SAMHSA-sponsored conference Improving Services for Individuals with Co-Occurring Substance Abuse and Mental Health Disorders, 11/13/95.

had a lifetime history of a mental disorder. Of those who reported a mental disorder, 29% reported that they also had an alcohol or substance use disorder. A lifetime alcohol use disorder was reported by 13.5%, and within that group, 45% reported the co-occurrence of another disorder. About 6% of those surveyed reported a lifetime substance use disorder (for a substance other than alcohol), and, within that group, 72% reported that they had another disorder. Data for disorders within the 12 months prior to the interview were proportionately lower than the lifetime data, but the overlaps were similar.

The ECA documented the widespread co-occurrence of psychiatric and substance-related disorders, not only in patient populations, but in the general population as well. More than 54% of respondents with a lifetime history of at least one DSM-III disorder had at least two disorders. Importantly, respondents with a lifetime history of at least one mental disorder had a relative-odds ratio of 2.3 of having a lifetime history of alcohol abuse or dependence, and a relative-odds ratio of 4.5 of having some other drug-related disorder, when compared with those who had no mental disorder.[56]

The National Co-morbidity Survey

The NCS gathered data between late 1990 and 1992 from a multistage household survey of about 8,100 individuals. A stratified sample, the individuals were selected to represent the uninstitutionalized population of the United States. Homeless persons and those in institutional settings were not sampled.

The age range of those interviewed in the NCS was 15 to 54. This range was selected to replicate the ECA methodology, while seeking greater detail about the sequence of onset of mental and substance-related disorders. By interviewing individuals as young as 15, it was possible to get a more complete picture of the first onset of disorders, including those that began in childhood. This study, funded by the NIMH and other sources, was carried out by the University of Michigan Institute for Social Research under the direction of Ronald Kessler, Ph.D. Dr. Kessler has been a significant contributor to this report.

The NCS used an interview instrument designed to determine the presence of disorders according the criteria in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised.* The NCS found that 48% of all respondents reported a lifetime history of at least one disorder, and 30% reported a disorder within the 12 months preceding the survey interview. The most frequent disorders were nonpsychotic conditions: affective (mood) and anxiety disorders. Of all the lifetime disorders reported, 79% were in persons with two or more disorders. **More than half of all disorders reported occurred in the 14% of those surveyed who had three or more disorders.**

It is important to note that the finding of a disorder in the NCS did not necessarily indicate impairment of function due to the disorder. The number of those with disorders is so high that some researchers await verification from other studies. As is the case with

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[56]Robins, L.N., Regier, D.A. Psychiatric Disorders in America: The Epidemiological Catchment Area Study. New York: Free Press, 1991.

every important research effort, some questions are answered and new ones arise. It seems important to repeat the NCS periodically, with modifications based on what has already been learned.

By integrating epidemiological data from the ECA and other studies with the NCS data, and adding estimates of the homeless and the institutionalized, Dr. Kessler estimates that up to 10 million people in the United States have a co-occurring substance-related and mental disorders in any given year.[57]

The NCS notes somewhat higher levels of both single and co-occurring disorders than were found in the ECA studies a decade earlier.[58] A hypothesis that may explain some of the rise in co-occurring disorders is that recent economic and social changes in the United States have brought about increased levels of anxiety and depression at earlier ages; these, in turn, have led to increased levels of self-medication with alcohol and illicit drugs. The NCS offers indirect support for such hypothesizing:

- In the population with co-occurring mental health and substance-related disorders, the mental disorder developed first in the vast majority of cases.
- The mental disorder tended to develop before or during the teen years.
- The substance-related disorder tended to develop several years later, in the late teens or early 20s.[59]

It must be stressed that there are wide variations in age of onset.[60] That the mental disorder develops first in the vast majority of cases, and that the substance-related disorder develops some years later provide us with some indirect support for the self-medication hypothesis of the etiology of some instances of substance-related disorders. It also points to a vitally important **window of opportunity:**

> **Early intervention with children and adolescents who have developed mental disorders may prevent the later development of a substance-related disorder, and thus may prevent co-occurring disorders.**

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[57]Kessler, R. The Epidemiology of Co-Occurring Addictive and Mental Disorders. NCS Working Paper #9. Invited conference paper, presented at the SAMHSA-sponsored conference Improving Services for Individuals with Co-Occurring Substance Abuse and Mental Health Disorders, 11/13/95.

[58]Kessler, R., Nelson, C., McGonagle, K. The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. American Journal of Orthopsychiatry 1996; 66: 17–31.

[59]Kessler, R. The Epidemiology of Co-Occurring Addictive and Mental Disorders. NCS Working Paper #9. Invited conference paper, presented at the SAMHSA-sponsored conference Improving Services for Individuals with Co-Occurring Substance Abuse and Mental Health Disorders, 11/13/95.

Kessler, R., Price, H. Primary prevention of secondary disorders: A proposal and agenda. American Journal of Community Psychology 1993; 21(5): 607–631.

[60]Kessler, R. The Epidemiology of Co-Occurring Addictive and Mental Disorders. NCS Working Paper #9. Invited conference paper, presented at the SAMHSA-sponsored conference Improving Services for Individuals with Co-Occurring Substance Abuse and Mental Health Disorders, 11/13/95.

This hypothesis has not been tested but offers a promising line of investigation for clinicians and researchers interested in prevention strategies.[61]

While the NCS was not designed to evaluate the effectiveness of treatment for co-occurring disorders, data from it note that only a minority of those who reported these disorders were in treatment. Fourteen percent of interviewees with at least one disorder actually had three or more. Most of the seriously ill and impaired clustered in this group. Only half of these individuals were receiving treatment of some kind. And most of them were being treated in general health programs, not in specialized mental health or substance abuse programs. Programs designed to treat co-occurring substance-related and psychiatric disorders are rare.[62]

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[61]Kessler, R. The National Comorbidity Survey: Preliminary results and future directions. International Journal of Methods in Psychiatric Research 1995; 5: 139–151.

[62]Services to Persons with Co-Occurring Mental Health and Substance Abuse Disorders. OEI-ot-94-00150 and OEI-05-94-00151. Washington, DC: Department of Health and Human Services, Office of the Inspector General, 1995.

Recommendations of the Data Track

The Data Track was asked to propose the research elements of a National Strategy for improving services for individuals with co-occurring substance abuse and mental health disorders. The track made the following recommendations:

General:

1. SAMHSA should develop guidelines on data collection and analysis for individuals with co-occurring disorders similar to the Center for Substance Abuse Treatment's TIPS practice guidelines for service providers.

2. SAMHSA should review the need for data and conduct a systematic analysis of existing data sets to determine what epidemiologic and services data are available.

3. SAMHSA should establish an ongoing mechanism (e.g., committee or consortia on co-morbidity data) to foster communication and information sharing among individuals and organizations (e.g., public and private organizations, consumers, universities, Medicaid, Medicare) having an interest in this population.

4. All entities should work to overcome legislative, policy, and programmatic barriers to data sharing.

5. SAMHSA and the National Institutes of Health (NIH) should open a reciprocal dialogue to promote the rapid collection, synthesis, and sharing of co-morbidity data.

6. SAMHSA, NIH, and others should develop epidemiologic and service information on discrete combinations of mental illnesses and substance use disorders.

7. SAMHSA should work with the States and other partners to improve the national data infrastructure.

8. SAMHSA should assist the States in the collection of usable State epidemiological and services data on co-morbidity, and in the production of State-by-State estimates.

9. SAMHSA should work to establish minimum co-morbidity data sets for all SAMHSA surveys, in collaboration with public and private partners.

10. SAMHSA and NIH should evaluate their knowledge transfer activities and improve use of communications technologies, such as the World Wide Web, and consumer health informatics.

11. SAMHSA and NIH should establish a speakers bureau for co-occurring disorders.

12. SAMHSA and NIH should establish productivity standards for grants regarding the content and quality of reports.

13. SAMHSA and NIH should attempt to improve the rapidity of data availability and published findings in peer reviewed journals.

14. SAMHSA and NIH should distill information on the biological underpinnings of co-morbidity and communicate it widely to the field.

15. SAMHSA should create a virtual scientific community that includes all relevant SAMHSA activities.

16. SAMHSA should foster and support basic training for State agencies in data collection and analysis needs and principles.

17. SAMHSA should provide training for grantees regarding data needs and principles.

18. SAMHSA, the States, and grantees should collect good advocacy data.

19. SAMHSA, the States, and grantees should ensure that studies are designed to reflect cultural diversity, and protect human subjects.

20. SAMHSA should continue the "conditions of participation" dialogue with the Health Care Financing Administration.

21. The Federal Government should exercise a sustained role in data coordination and facilitation.

21A. SAMHSA should ensure that all grants for homeless and criminal justice populations collect uniform data on co-morbidity, treatment provided, and outcomes. They must be based upon meaningful indicators of clinical, functional, and quality of life issues.

Epidemiology:

22. SAMHSA should encourage community and treatment epidemiology data collection and analysis efforts, to emphasize longitudinal features of recovery and other outcomes.

23. Treatment epidemiology should include specialty, health, social services, self-help, and educational services, and should take community and treatment context into account.

24. Data collection activities should use core measures, and these should be institutionalized to enhance the cumulative nature of the work.

25. The need for national coordination of the data infrastructure for epidemiology should be recognized.

26. A secondary analysis of studies such as the NCS should be done and should be widely disseminated.

Service Delivery:

27. There is a need to standardize variables regarding access, availability, integration, relapse prevention, day treatment, etc.

28. There is a need to link client data across systems, with due regard for informed consent and client protection.

29. There is a need to measure active elements and fidelity to best practices.

30. There is a need to measure adequacy, reliability, and validity of therapist-generated data, at the level of services, agency, and county.

31. There is a need to relate epidemiologic and services data sets, including the prevention and treatment services match to need.

32. There is a need to develop treatment and services indexes, such as the Lehmann quality of life measure.

Cost:

33. There is a need to initiate pilot work on comparative cost studies, to define minimum data elements of traditional and alternative treatment services, and to perform baseline studies in Medicaid/Medicare.

34. There is a need to encourage cost analyses within programs, including secondary costs associated with primary services, and the cost of no treatment and treatment "as usual," compared to integrated treatment.

35. There is a need to plan and prepare for the collection of longitudinal cost data.

Effectiveness/Outcome:

36. There is a need to ensure that studies are simple but multidimensional. They should collect information on minimum elements from provider and consumer perspectives. For example, psychiatric and psychological symptoms, retention in treatment, level of functionality, change in adverse consequences.

Chapter III: Children and Adolescents

Why and how do co-occurring substance-related and mental disorders develop, and how do they affect children, adolescents, and their families?

Data from the *National Co-morbidity Survey* (NCS) and other sources indicate the early onset of both substance-related and mental health disorders. These and other studies show that many disorders begin in childhood and adolescence and tend to become persistent and disabling if not treated early. Yet the focus of treatment programs has tended to be on adults. Opportunities for primary prevention and secondary prevention (preventing an existing disorder from worsening or a second disorder from developing) have not been capitalized on.

Recent changes in the U.S. economy and social changes are challenging the mainstay of children's development: the family. As parents have come under increasing pressures of their own, family support for children has sometimes weakened. Are these changes risk factors for the development of substance-related and mental health disorders?

The experience of being a child has changed significantly in recent years. A special issue of *The New York Times Magazine*, published October 8, 1995, was devoted to documenting the effects of these changes. More children are growing up

- in single parent homes;
- in two-parent homes where mother and father are both working;
- in communities in which drugs are readily available and drug use among children and adolescents is rampant;
- on streets and in schools where there is a sense of physical danger;
- spending more time watching TV than in school.

A study of a birth cohort from ages 3 to 18 documented the continuity of childhood disorders through adolescence.[63] Boys appeared to be more vulnerable, and those from socially and economically disadvantaged backgrounds had an elevated risk of developing disorders by age 18. This study argues against a commonly held view that children do not necessarily need help with early-onset disorders, because they will probably "grow out of it."

Despite the greater public concern about adolescent substance abuse, alcohol abuse among teens remains a major problem. In a community sample of over 1,500 adolescents between 14 and 18 years of age, it was noted that over 80% of those with alcohol abuse or

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[63]Feehan, M., McGee, R., Williams, S.M., Nada-Raja, S. Models of adolescent psychopathology: Childhood risk and the transition to adulthood, Journal of American Academy of Child and Adolescent Psychiatry 1995; 34(5): 670–679.

dependence had a mental disorder.[64] The alcohol disorder generally developed **later** than the mental disorder. This strikingly high rate of co-occurring disorders merits concern.

The use of marijuana among adolescents is on the rise. In 1991, only 2% of high school seniors (12th grade) were using this drug on a daily basis. By 1995, according to the National Institute on Drug Abuse study, *Monitoring the Future*, 4.6% were smoking marijuana daily.[65]

There is much debate over the large numbers of children who have been diagnosed as having ADHD (attention deficit disorder with hyperactivity). One source[66] estimates the number of children with this disorder at 5 million. Many are prescribed methylphenidate (Ritalin) or other stimulant or antidepressant medications.

After reviewing the literature on co-occurring substance-related and mental health disorders in adolescents, Belfer[67] recommends that those who have conduct or depressive disorders be assessed carefully for substance-related disorders. Even if there is no substance-related disorder present, a **preventive** stance is recommended.

Families are under greater economic pressure, because most mothers, including those with husbands, are out working at paid employment and are still responsible for raising their children. Government financial support for poor families is declining, putting parents under even greater stress and allowing them less time and fewer resources for parenting.

Treatment agencies and schools are struggling to adapt to the current needs of children for prevention and treatment. Mental health programs are not structured to skillfully assess and treat co-occurring mental health and substance-related disorders. Staff often lack needed cross-training. Most substance abuse programs were created to serve adults a few decades ago, when it was not thought that significant numbers of adolescents needed such treatment.

Documentation of the development of co-occurring substance-related and mental health disorders is becoming more available, as researchers focus on risk and onset factors in the child and adolescent population. A study in New Haven compared adolescents in a psychiatric hospital who had a substance-related disorder with those who did not. It found that the presence of a substance-related disorder predicted high rates of co-occurrence with mental disorders.[68]

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[64]Rohde, P., Lewinsohn, P.M., Seeley, J.R. Psychiatric comorbidity with problematic alcohol use in high school students. Journal of American Academy of Child Adolescent Psychiatry 1996; 35(1): 101–109.
[65]Center for Substance Abuse Research Fax, 1996; 5: Issue 1.
[66]Alexander-Roberts, C. The ADHD Parenting Handbook, 1994; 1.
[67]Belfer, M.L. Substance abuse with psychiatric illness in children and adolescents. American Journal of Orthopsychiatry 1993; 63(1): 70–79.
[68]Grilo, C.M., Becker, D.F., Walker, M.L., Levy, K.N., Edell, W.S., McGlashan, T.H. Psychiatric comorbidity in adolescent inpatients with substance use disorders, Journal of American Academy of Child Adolescent Psychiatry 1995; 34(8): 1085–1091.

The general trend seen in the 1992 NCS data is that the median age for onset of meeting diagnostic criteria for mental disorders is about 11, and for substance abuse disorders, somewhere between 17 and 21. These data reflect the age at which the individual met criteria for a disorder, not the earlier age when symptoms first developed. Furthermore, there is evidence that age of onset may be different for children from special populations, such as the poor and ethnic minorities. For example, 66% of juveniles arrested tested positive for cocaine, marijuana, or phencyclidine, according to May 1995 data from Washington, DC.[69] Seventy-five percent of those arrested who were 17 years of age tested positive for one of these three drugs.

The NCS data further indicate that for nearly 90% of the individuals in the household sample with co-occurring substance-related and mental health disorders, the mental disorder developed first. These data imply support for the self-medication hypothesis for co-occurring substance-related and mental health disorders.

It is noteworthy that, in a Maryland survey of high school seniors, inhalants were used even earlier than alcohol and illicit drugs.[70] Sixty-three percent of those who had ever used inhalants—such as paint thinners, aerosols, gasoline—did so before the age of 12. Use of alcohol and marijuana began later, at 15 and 16. However, among adolescents whose mean age was nearly 17 and who were concerned enough to call a hot line about their drug and alcohol use, the mean age of first alcohol and marijuana use was, respectively, 13.57 and 13.28.[71] Children and adolescents with an emotional disorder are within the population that is more vulnerable to readily available and affordable inhalants, alcohol, and illicit drugs.

The implications for substance abuse prevention programs are evident: Children with mental health problems of anxiety, conduct disorder, ADHD, or depression are an extremely high-risk population for the development of substance abuse disorders.[72]

Ryglewicz and Pepper[73] emphasize that adolescent mental health and substance-related disorders disrupt normal skill development. They recommend that treatment and rehabilitation focus on the possible need for **habilitation;** that is, for assistance in developing needed skills and functions that were bypassed while the child was struggling with untreated mental and other disorders.

Despite the great need for objective data, little research has been done to evaluate treatment protocols for children who have, or are at risk of developing, co-occurring

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[69]Center for Substance Abuse Research Fax, 1995; 4: Issue 30.
[70]Center for Substance Abuse Research Fax, 1996; 5: Issue 3.
[71]Dupre, D., Miller, N., Gold, M., Rospenda, K. Initiation and progression of alcohol, marijuana, and cocaine use among adolescent abusers. American Journal on Addictions 1995; 4(1): 41–48.
[72]Grilo, C.M., Becker, D.F., Walker, M.L., Levy, K.N., Edell, W.S., McGlashan, T.H. Psychiatric comorbidity in adolescent inpatients with substance use disorders. Journal of American Academy of Child and Adolescent Psychiatry 1995; 34(8): 1085–1091.
[73]Ryglewicz, H., Pepper, B. Compromised development: The complex plight of young adults with mental/emotional disorders. Adolescent Psychiatry Developmental and Clinical Studies 1989; 16: 278–287.

substance-related and mental health disorders. This situation is likely to be improved by the impending National Institute of Mental Health launch of Mental Health Service Use, Needs, Outcomes and Costs in Child and Adolescent Populations, a children's version of the Epidemiologic Catchment Area Study.[74]

Shore,[75] in a review of two new books on adolescents, summarized reports from the National Research Council[76] and the Carnegie Foundation.[77] He noted four elements that are characteristic of successful adolescent services: **accessibility, flexibility, comprehensiveness, and advocacy.** He opines: "There is no doubt that we need a national youth policy, one that takes into account all the social forces impinging on adolescent development. Indeed, we might perhaps compose a youth-impact statement to accompany legislation, much in the manner of an environmental impact statement."

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[74]Burke, J.D., Burke, K.C., Rae, D.S. Increased rates of drug abuse and dependence after onset of mood or anxiety disorders in adolescence. Hospital and Community Psychiatry 1994; 45: 451–455.
Kessler, R., Price, H. Primary prevention of secondary disorders: A proposal and agenda. American Journal of Community Psychology 1993; 21(5): 607–631.
[75]Shore, M.F. Is there a future for youth? Readings 1996; 11(2): 18–21.
[76]National Research Council. Losing Generations: Adolescents in High Risk Settings. 1993.
[77]Great Transitions: Preparing Adolescents for a New Century. Carnegie Council on Adolescent Development, 1995.

Recommendations of the Child and Adolescent Track

The Child and Adolescent Track grouped its recommendations in response to several key questions that were posed in the technical materials circulated to conference participants. The recommendations are listed below.

1. The Knowledge Base:

i. SAMHSA should promote collaboration between and across agencies that maintain data sets on co-morbid children. To enhance data sets, children should be tracked through the collaborating agencies.

ii. The National Institutes of Health should consider concerns about services in the UNOCCAP study and encourage SAMHSA participation. Juvenile justice children should also be included in the study.

iii. There must be identification of effective treatment programming in community-based studies.

iv. Managed care and other private sector agencies must focus on creating a framework for quality care to include standards of quality care.

v. SAMHSA must market data on the incidence and prevalence of children's mental health and substance abuse (MH/SA) problems as a way of promoting quality care and, therefore, affecting the future.

vi. The dissemination of information should be provided in a manner that
— people can easily identify with,
— makes sense to the public,
— puts a face on the problem,
— can personalize the problem for families and systems (i.e., a national campaign similar to the Ad Council's "egg/brain on drugs ad").

vii. Orchestrate the implementation of the above points to design a system to impact clinical practice.

2. Prevention:

i. Understand early antecedents at adolescence and beyond it.

ii. Intervene during time of first use.

iii. Look at children on a developmental trajectory—establish standards that parents can use to promote children's health.

iv. Offer help to parents, particularly new parents and teen parents (i.e., the use of home visits).

v. Focus on and invest in communities.

vi. Promote good health by building on the wellness and strength of children.

vii. Examine the risk and resiliency issues of prevention.

viii. Look at the environmental conditions that promote MH/SA problems.

ix. Look at prevention on a continuum—it is consistent, ongoing, and long term.

x. Develop leadership prevention strategies:

— identify leaders who are promoting quality children's MH/SA services;
— provide training across disciplines for all those providing services to children;
— work collaboratively with agencies advocating for children.

xi. Take a holistic approach to children's MH/SA services.

GENERAL RECOMMENDATION TO SAMHSA: SAMHSA should develop a mechanism within the agency to address the issues of co-morbidity in children and, by so doing, serve as a model for the Nation regarding the integration of services. To implement this mechanism, there should be a coordinator of children's co-morbidity issues who has line authority.

3. Roles:

i. SAMHSA's role:
Dissemination of Information
— Getting the message out
— Effective use of the media

ii. Role of MH/SA agencies, schools, and State and local governments
— Developing partnerships to go directly into the schools—working directly with children.
— Working with the alcohol and tobacco industries and others to change the use of these drugs (i.e., change in smoking behavior in the media: how did this happen? what can we learn?)
— Providing early education for children—tools for coping with life.
— Early identification of those at risk.
— Promoting abstinence as an option to alcohol and tobacco use.

4. Child Abuse and Co-occurring Disorders:

i. Get out the information regarding the connection between child abuse and co-morbidity.

ii. Prevent the trauma of child abuse as much as possible.

iii. Intervene quickly after trauma.

iv. Create more resources to deal with the problem of child abuse and co-morbidity.

v. Conduct research to obtain more information on child abuse and co-occurring illness.

vi. Provide gender-specific programming for both males and females.

vii. Develop better social skills for both sexes—teach boys about interacting with girls and vice versa.

viii. Develop a policy of cultural sensitivity as this complex issue is explored.

ix. Develop a collaboration and promote ongoing communication between program and research on this issue.

x. SAMHSA's contribution to this effort should be to tell the field how to measure program effectiveness.

5. Assessment and Diagnosis:

i. Current assessment instruments need improvement. Data studies are needed that develop or test assessment instruments.

ii. Assessment instruments must address cultural competence:
— recognize different definitions of MH/SA within different cultures;
— build on current studies;
— work with sister agencies and develop cooperative agreements;
— obtain cofunding and work to break down turf issues;
— develop both process and outcome measures.

6. Financing:

i. Needed: A financial infrastructure to support MH/SA services for children and identification of blended money for financing children's services.

Barrier: Blended money often results in poor funding or no funding; money appears to dry up.

ii. Needed: Parents' groups that stand up for children in a way that affects legislation.

Barrier: The stigma of having a child with MH/SA disorder
— Families have needs and there must be a consistent and ongoing effort on the part of families to really affect legislation

iii. Needed: Federal, State, and local government money to do the activities listed above.

Barrier: The current trend is for the Federal Government to move away from system and leadership issues.

iv. Needed: Research on what children need to do well; outcome-based financing on behalf of children and families.

Barrier: Good, new ideas on how to structure programs for children need to be researched, which will require funding.

v. Needed: SAMHSA as the Federal agency to act as the architect in designing critical services for children.

Barrier: Managed care money doesn't play the architect role.

vi. Needed: Educate and raise the awareness of State systems regarding the needs of children.
— Promote the big picture—children as "human capital"—as a way of protecting the future workforce.
— Make the case that society is responsible for children who can not be responsible for themselves.
— Government has a role to play in saving children and providing money for children's services.

vii. Needed: Healthy children who are well trained and educated.
— Sell business on how quality children's services affect next quarter's earnings.
— Bring in representatives from industry to show how they can help children become more productive in the future.

— Federal Government must provide State and local governments with reliable and useful data, specifically on how to measure outcomes and how to hold managed care accountable.
— The environment must be established where government and business come together out of self-interest.
— SAMHSA should set the quality of care standard by ensuring that all SAMHSA activities have outcome measures.

viii. Needed: Public and private sector collaboration in providing MH/SA services to children, building on the expertise developed by the public sector in this area.
— Good policy and good science that lead to quality standards for managed care.

Barrier: Currently the public sector does not have the outcome data to sell and promote MH/SA services.

Chapter IV: Best Practices

What kinds of prevention and treatment services work best?

Programs designed to treat persons with co-occurring substance-related and mental health disorders are few and relatively new. In the main, they have not been objectively evaluated for effectiveness. This is not surprising, considering the fact that an "old" program designed to provide such treatment is usually less than 8 years old, and most are 2, 3, or 4 years old.[78]

The importance of secondary prevention is underscored in a study of the long-term course of patients with severe mental illness who have substance-related disorders. A 7-year followup of severely mentally ill outpatients found that those with initial alcohol or drug abuse had better outcomes than those with initial alcohol or drug dependence. The differential rate of change for those who were treated before their abuse might have progressed to dependence suggests the possible value of earlier intervention.[79]

Because of these severe limitations, SAMHSA proposes a National Strategy to locate and evaluate the most effective programs, treatment protocols, and tools currently available to treat persons with co-occurring substance-related and mental health disorders. New programs are now being tried and tested. A strategy to locate, develop, evaluate, and promote successful models is crucial to SAMHSA's goal of improving services for persons with co-occurring substance-related and mental health disorders.

The Conceptual Frame: Treatment Models

Serial Treatment: The earliest model for treating persons with co-occurring substance-related and mental health disorders arose as a response to the system—or nonsystem—of discrete treatment programs, each of which treated a single disorder. Serial treatment refers to treating one disorder until it is under control and then referring the client to another agency to treat the other co-occurring disorder.

An example of serial treatment occurs when a person with schizophrenia and an alcohol problem is referred to an alcohol treatment program until a period of abstinence has been maintained for several months, at which time a mental health agency might accept the client for medication and begin treatment of the schizophrenia.

Alternatively, the alcohol treatment agency might refuse to treat the client until the mental health agency first brings the schizophrenia under control. At that time the substance

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[78]Services to Persons with Co-Occurring Mental Health and Substance Abuse Disorders. OEI-ot-94-00150 and OEI-05-94-00151. Washington, DC: Office of the Inspector General, Department of Health and Human Services, 1995.

[79]Bartels, S.J., Drake, R.E., Wallach, M.A. Long-term course of substance use disorders among patients with severe mental illness. Psychiatric Services 1995; 46(3): 248–251.

abuse agency might treat the alcohol problem, or might refuse to do so because agency policy rejects clients who are on any drug, including prescribed medication.

Serial treatment has led to clients being shuttled between agencies, each agency usually preferring to be second in the treatment line.

Simultaneous, coordinated parallel treatment: In this model, two agencies work with the client at the same time, each treating one disorder. Theoretically, the agencies exchange information about the nature and effectiveness of their treatment and about developments in the client's life. Experience shows that, even with the best of intentions, adequate information exchange is often a problem.

A second problem develops when one agency proposes activities or goals that contradict or are incompatible with those of the other. One agency may propose confrontation as the preferred treatment approach, while the other may feel that the client is too fragile to tolerate such confrontation. One agency may prescribe medications that are proscribed for clients of the other agency.

Integrated treatment: Integrated treatment refers to the simultaneous treatment of all disorders by an appropriately dually trained clinician, or a unified treatment team whose members are competent to treat both the substance-related and the mental health disorders. Ideally, the team members work for one agency. In unusual cases, two agencies may collaborate to create a comprehensive, unified team. It is the team's responsibility to create a treatment plan that recognizes the interconnectedness and complexity of the psychiatric symptoms and the substance use.

For example, the members of an integrated team may be able to work with the team psychiatrist to decide the following: Should medication for severe depression be prescribed before abstinence has been obtained? The risk of medicating before abstinence is securely attained must be weighed against the client's inability to abstain from alcohol or other drug use while profoundly depressed. The shared perspectives and shared risk-taking can provide a rich opportunity for cross-training in the workplace and for integrated treatment.

There are several difficulties that make integrated treatment difficult to implement:

- Funding streams are separate and usually cannot be combined.
- Resolution of agency turf issues may be impossible.
- There may be legitimate differences in professional philosophy as to how to best proceed with treatment.
- Staff may lack the minimum degree of cross-training needed to be able to work together and understand each other's vocabulary and techniques.
- Multiple, pressing needs for housing, medical care, and vocational training may need to be addressed before treatment for co-occurring disorders can be successful.

Outcome data on the costs and effectiveness of treating co-occurring disorders are just beginning to be collected and published. Early unpublished data from the Florida Center

for Addictions and Dual Disorders[80] report marked improvement in clinical outcomes with significantly reduced costs as a result of shifting the program model from residential addictions treatment to **integrated** residential treatment for co-occurring disorders.

In a prospective study of 47 patients with schizophrenia and substance abuse disorders, patients were randomly assigned to integrated treatment or nonintegrated outpatient treatment. The study found that patients assigned to integrated treatment were likelier to develop and maintain a connection to the program. Program retention, in turn, was associated with fewer rehospitalizations, increased sobriety, and decreased psychiatric symptoms over the first 8 months of treatment.[81]

A drug dependence clinic studied 222 veterans referred for substance abuse treatment. The clinic provided comprehensive diagnostic services. The 46%, or 103, who were found to have co-occurring mental disorders were provided with integrated treatment. This group was found to do less well initially than the veterans who exhibited only substance abuse disorders. However, in the presence of psychiatric care, those with co-occurring disorders eventually did as well as those without psychiatric disorders.[82]

While much research on treatment outcomes is needed, early studies of the effectiveness of integrated treatment have produced positive outcomes. Drake and his colleagues[83] summarized the available data on outcomes of integrated treatment, and conclude that:

> Ten years ago, the only treatment options available for people with co-occurring substance abuse and severe mental illnesses were parallel treatments in separate programs. These efforts were often uncoordinated and ineffective, leading to pessimism regarding outcomes for patients with dual disorders. Over the past ten years, programs that integrate substance-abuse and mental health treatments have been rapidly emerging. Initial evidence indicates that integrated treatments, if consistently applied over several years, are quite effective. Clients in integrated treatment programs achieve remission or recovery from substance abuse at a more rapid rate than would be otherwise expected and experience improvements in other outcome domains correlated with substance abuse, such as residential stability. Public policy changes must encourage providers to assume longitudinal responsibility for these highly vulnerable clients.[84]

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[80]Cox, A. Letter to Max Schneier, May 13, 1996.

[81]Hellerstein, D.J., Rosenthal, R.N., Miner, C.R. A prospective study of integrated outpatient treatment for substance-abusing schizophrenic outpatients. American Journal on Addictions 1995; 4(1): 33–42.

[82]Saxon, A.J., Calsyn, D.A. Effects of psychiatric care for dual diagnosis patients treated in a drug dependence clinic. American Journal of Drug & Alcohol Abuse 1995; 21(3): 303–313.

[83]Drake, R.E., Noordsey, D.L., Ackerson, T. Integrating mental health and substance abuse treatments. In Double Jeopardy: Chronic Mental Illness and Substance Use Disorders. Lehman and Dickson, eds. Chur, Switzerland: Harwood Academic Publishers, 1995; 251–264.

[84]Drake, R.E., Mueser, K.T., Clark, R.E., Wallach, M.A. The course, treatment, and outcome of substance disorder in persons with severe mental illness. American Journal of Orthopsychiatry 1996; 66(1): 42–51.

Osher has summarized the situation succinctly:

> With empirical research and clinical experience supporting the effectiveness of integrated approaches, the time has come to reconsider the systemic division of addictive and mental health services. A change toward integrated systems of care is likely to benefit the mental health addiction treatment needs of all people, not just those with co-occurring disorders.[85]

[85]Osher, F.C. A vision for the future: Toward a service system responsive to those with co-occurring addictive and mental disorders. American Journal of Orthopsychiatry 1996; 66: 71–76.

Recommendations of the Best Prevention and Treatment Track

Co-occurring mental health and substance abuse disorders are treatable conditions. There was consensus within the expert panel that integrated treatment—the simultaneous attention to both disorders by appropriately skilled and experienced treatment professionals—is the most effective approach in addressing co-occurring disorders. The panel also recognized that persons with co-occurring disorders have needs in other life domains that must be addressed for treatment to be successful. These include the lack of safe, affordable, and adequate housing; inadequate income or vocational skills; multiple health disorders; and frayed support networks.

The Best Prevention and Treatment Practices Track expert panel recommended that SAMHSA adopt and promulgate the following principles and practices:

Policy Initiative. That SAMHSA provide national leadership in addressing co-occurring disorders by pursuing the following policy initiatives.

- Reconvene the expert panel for a meeting between SAMHSA and the Office of National Drug Control Policy (ONDCP) to emphasize the importance of addressing co-occurring disorders as a national policy. This national effort should include Department of Health and Human Services agencies, public officials, and members of Congress, as well as family, consumer, and professional organizations.

- Develop standard language on the prevalence and treatment of co-occurring disorders. This language should appear in all DHHS health care policy statements.

- Stimulate coordination between mental health and substance abuse treatment programs at the State level in addressing co-occurring disorders by including specific performance objectives in the respective performance partnership/block grants. SAMHSA should assertively monitor these plans.

- SAMHSA should convene administrators and researchers from the National Institute on Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcoholism and Alcohol Abuse to establish a research agenda on effective treatment and services research on co-occurring disorders. SAMHSA's limited demonstration resources can be maximized by jointly funding significant projects with these research institutes.

Prevention. Prevention efforts will be improved through the following:

- SAMHSA should develop a National Strategy on prevention, focused specifically on antecedents of co-occurring disorders. This should include early detection, education, and the provision of services for those at high risk for development of co-occurring disorders (i.e., children with learning disorders; persons experiencing trauma, including child or domestic abuse; persons with predisposing family conditions, etc.).

- Service providers should incorporate substance abuse prevention and education efforts into all service programs targeted to those with serious mental illnesses, and should incorporate mental illness prevention and education efforts into all substance abuse treatment programs. Such initiatives must address reducing the stigma associated with receiving treatment for mental health and substance use disorders, including both staff and client/patient perspectives.

- Client/patient assessment should routinely include determinations of family histories of co-occurrence. Such incidence is a risk marker that implies the need for prevention and education interventions.

Access to Integrated Treatment. Access to comprehensive, integrated treatment is best accomplished at the provider and community level. Access will be improved through the following:

- Promoting the integration of mental health and substance abuse treatment services so that treatments specifically responsive to co-occurring disorders are available.

- Treatment programs having professional staff, or access to professional staff (including physicians, nurses, social workers, counselors, and psychologists), trained in the treatment of co-occurring disorders.

- Treatments that are relevant and sensitive across culture, ethnicity, and gender.

- Treatment programs with a longitudinal perspective that recognizes and works with clients across stages of treatment, relapse, and recovery. This includes the recognition that treatment and recovery are not linear. Relapse is an inherent characteristic of chronic, episodic disorders and is an expected feature in recovery from serious mental illnesses and substance use disorders.

- Treatment models based on rehabilitation and recovery concepts, as well as appropriate medical interventions, which eschew judgmental and moralistic overlays.

- The recognition that an assertive approach is often essential in addressing co-occurring disorders.

- The development and use of the therapeutic alliance to foster client engagement in the treatment process, client consistency in treatment, and positive treatment outcomes.

- A sense of optimism among staff. Data support the effectiveness of treatment for individuals with co-occurring disorders, with integrated approaches demonstrating the highest degree of effectiveness.

- The recognition that a small percentage of clients will require a high level of intensive treatment and related services, and that most clients/patients will respond to integrated services consistently with principles expressed herein.

Treatment Quality. Treatment quality must be a concern at local, State, and national levels. Improvements in treatment quality will occur by

- Fostering professional education on co-occurring disorders through training scholarships, career development awards for faculty, and funding support for cross-training.

- Refining the assessment and identification of co-occurring disorders, including the following:

  — the development of comprehensive and diagnostic protocols that are sensitive to the detection of co-occurring disorders and to differential patterns of association between these disorders;
  — instruments for screening, assessment, diagnosis, and tracking/followup that are culturally relevant and sensitive; and
  — methods that are comprehensive across the multiple domains of client need.

- A recognition that reciprocal interaction between serious mental illnesses and substance use disorders may create a negative synergy whereby deterioration or relapse in one disorder exacerbates the other. Co-occurring mental health and substance use disorders can be separated but are interdependent. Treatment of, and improvement in, one disorder does not assume improvement in both. Severity of either or both disorders generally necessitates a longer course of treatment.

- Treatment specificity and the use of flexible, individualized treatment plans that are contingent on the patterns of association between the co-occurring disorders, their severity, client needs, and the availability of a comprehensive service approach that can respond to critical client domains, including health care, housing, income supports, wraparound services, and case management.

Evaluation. Evaluation of the clinical effectiveness of co-occurring treatment programs should be a standard practice. Such efforts would be strengthened by the following:

- Development of new criteria for success that recognize relapse and maintenance as inherent in chronic, episodic disorders and that include consideration of clinical improvement, functional abilities, quality of life issues, and maintenance in the community.

- The field needs to recognize the principle of treatment evolution: that best practices change with the addition of knowledge and experience about these disorders, and that there is an ongoing need for innovative treatment approaches based on research and evaluation.

- For treatment programs, monitoring and quality assurance should be assertive program components in any organized response to co-occurring disorders.

Chapter V: Education and Training

Have clinicians been trained to assess, diagnose, and effectively treat individuals with substance-related and mental health disorders?

Nearly all of today's clinical professionals and program staff were trained to work with individuals having a single substance-related or mental health disorder. For this reason, there is virtual unanimity among those in both the mental health and the substance abuse treatment fields that cross-training is an essential first step in improving treatment for persons with co-occurring substance abuse and mental health disorders.[86]

Mental health professionals who were trained more than a few years ago may have received little or no training about addictive disorders. Even basic training on this topic can substantially improve their ability to be helpful to individuals with co-occurring disorders. Similarly, many addiction counselors have had little or no training in diagnosing and treating mental disorders.

As a result, co-occurring disorders often go undetected, leading to inadequate or inappropriate treatment. For example, Wilkins and colleagues[87] reported on 56 consecutive admissions to a psychiatric hospital. Sixty-two percent had urine tests that were positive for at least one drug of abuse. The admitting physician failed to identify drug use in 66% of those with positive urines. Interestingly, the physicians' assessment matched the statement of 79% of the patients. Specifically, of the 26 patients with positive urines who denied recent drug use, all but one received a negative assessment for drugs from the admitting physician.

The second training issue that must be addressed focuses on changing the current educational curricula and courses for future generations of students. The recommendations in this chapter propose ways in which a National Strategy can encourage and assist universities and other institutions involved in substance-related and mental health education and training to give full consideration to the treatment needs of persons with co-occurring substance-related and mental health disorders.

What training have today's practitioners received?

In a pair of reports issued in 1995, the Inspector General (IG) of the Department of Health and Human Services followed up on the National Co-morbidity Survey (NCS) by surveying, describing, and reporting on the staff of 30 programs that were created to provide comprehensive and integrated treatment to persons with co-occurring disorders in community settings. One IG report is called "Program Descriptions;" the other, called

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[86]Mental and Substance Use Disorders: The Treatment of Dual Diagnosis. A Policy Report for the Washington Metropolitan Region. Washington, DC: Metropolitan Washington Council of Governments, 1995.
[87]Wilkins, J.N., Shaner, A.L., Patterson, C.M., Setoda, D., Gorelick, D. Discrepancies between patient report, clinical assessment, and urine analysis in psychiatric patients during inpatient admission. Psychopharmacology Bulletin 1991; 27(2): 149–154.

"Provider Perspectives," describes the staff and their training. The reports provide descriptive data, because these were pilot efforts.

The IG reports deal only with outpatient, day treatment, and residential services (these are referred to as "community-based" in the report); they do not cover any hospital-based treatment. The reports provide no information about the role, function, or need for psychiatric services. This is an important omission, because only psychiatrists (or other physicians) can prescribe medication for schizophrenia, bipolar illness, severe depressive disorders, or severe anxiety disorders. **Presumably these programs, although designed to provide comprehensive treatment, must actually be providing parallel treatment by referring their clients to outpatient psychiatric clinics or privately practicing psychiatrists for their medications.**

Of the 46 staff members who provided data on their educational attainment, one is a Ph.D. psychologist and none are M.D.s. Fifty percent have a master's degree, most are in a field other than social work or psychology. Twenty-eight percent have only a bachelor's degree, 9% have a high school diploma, and 11% have a nursing degree.

The respondents and program administrators in the IG reports all note that they are dealing with a severely mentally ill, substance abusing, disabled population of individuals. The report notes that clients most in need of expert professional help are being treated by staff who, willing and dedicated as they are, note their own lack of adequate training and education. Nevertheless, they are treating very ill, chronic, disabled clients with multiple mental health, substance-related, health, economic, housing, and family problems.

The IG reports note that few, if any, outcome data are collected or reported by the programs they surveyed, and so they have little to offer in the way of clinical, functional, or quality of life outcomes of their treatment efforts. The reports note that the clients in the programs surveyed

- are usually in their 20s or 30s;
- usually have other serious social, medical, and financial problems;
- often belong to a minority group;
- often come from a disadvantaged family; and
- often have a personal history of trauma.

In addition to the compelling data in the IG reports, the need for increased training for co-occurring substance-related and mental health disorders is implied by the NCS, the Epidemiological Catchment Area, and numerous other clinical and research studies. Such studies indicate that only a minority of individuals with co-occurring substance-related and mental disorders are treated in **either** mental health **or** substance abuse specialty agencies, or by specialist individual practitioners. Much of the treatment that does occur is provided in the general health area. Despite the abundance of such evidence, recent years have seen a marked decline in governmental support for specialty education in both substance abuse and mental health.

The Federal government has traditionally played a crucial role in expanding training opportunities and launching new professions, when such action was seen as necessary for the public good. For example, a good deal of the growth of the mental health professions was aided by Federal supports for curriculum development and for fellowships. However, Government funding for professional education has been reduced over the past few years.

Recommendations of the Education and Training Track

1. **General Principle**—General Training and Education
   Trainees: All clinicians who are currently in training should be required to graduate with a basic and adequate understanding of, and ability to assess, intervene, and treat, co-occurring substance abuse, and mental health disorders. All clinicians who are currently in practice should be encouraged and assisted in getting additional training in substance abuse, mental health, and co-occurring disorders. All clinicians should be reasonably knowledgeable about addictive and mental health disorders and be able to provide integrated treatment in a culturally competent and professional manner.

   Educators: The training of educators for undergraduate and clinical graduate education for addiction, mental health specialty, and general health care professionals should be improved to ensure that co-occurring addictive and mental disorders, and the potential for such disorders, are recognized and addressed. Mechanisms and materials that work best to deliver continuing education and multidisciplinary training to practicing clinicians should be developed. Methods should be developed to improve the application of new knowledge.

   Specific Recommendations: (**Note:** The group had intended to have the Specific Recommendations grouped as they pertained to either those in training or educators. Time constraints prevented final discussions. As can be seen, some of these recommendations do not fall clearly in either category.)

   a. There should be an assessment of the training needs for program and staff (**Note:** This was discussed in terms of all levels—Federal, State, local, and program).

   b. The basic knowledge and skills for diagnosis and treatment of co-occurring disorders should be clearly defined.

   c. Core clinical and administrative competencies should be defined.

   d. Standardized instruments for the assessment and treatment of co-occurring disorders should be developed and utilized.

   e. Treatment outcome evaluation and service research should be further developed and utilized in training and education.

   f. Short-term and long-term integrated training for clinicians should be developed.

   g. Longitudinal training programs should be developed and their effectiveness monitored.

h. The training of educators should be improved in order to upgrade the undergraduate and clinical graduate education of substance use and mental health professionals.

i. A critical mass of trained professional and academic staff should be developed.

j. Opportunities should be developed for faculty and educators to obtain ongoing practical experience in service delivery in nonacademic settings.

k. Interdisciplinary and collaborative training should be required.

l. The costs of training for clinical staff, academicians, and educators and of developing training programs must be acknowledged (especially with the current trends in managed care).

m. Granting agencies (e.g., Federal, State, foundations) must be encouraged to support training for development of faculty and educators in co-occurring disorders.

2. **General Principle**—Curricula

Specific curricula for training staff to treat co-occurring addictive and mental health disorders should be developed to train professionals, primary care providers, psychiatrists, psychologists, social workers, nurses, and addictions counselors. Professional education should be combined to train professionals in both substance-related and mental health disorders. Curricula should be used for training a cadre of new professionals who are specially prepared to provide such treatment. Curricula and training programs should incorporate emerging research and practices of managed care to ensure optimum provisions for services. Incentives and alternative strategies should be developed to engage academic centers to accomplish these goals.

Specific Recommendations:

a. Curricula should be designed to prepare students to acquire basic knowledge and skills and to develop core competencies to provide integrated services to individuals with addictive, mental health, and co-occurring disorders.

b. Strategic planning and specific models for incentives to change current practices should be emphasized for the diagnosis, treatment, and delivery of health care to individuals with co-occurring disorders.

c. Postdegree training should be developed and expanded to produce specialists and experts in the diagnosis and treatment of co-occurring disorders.

d. Federal agencies should encourage collaboration between Single State Agencies and universities for the provision of training (**Note:** The group endorsed

Arkansas' plan to get the State out of providing direct treatment and shift the State role to providing technical assistance and monitoring).

3. **General Principle**—Overcoming Resistance to Collaboration

Strategies should be developed to overcome staff's biased attitudes, stereotyping, and resistance in order to facilitate collaboration and cooperation as indicated for integrated services for clients with co-occurring disorders. Incentives should be developed that are likely to attract more substance abuse and mental health providers to increase their knowledge of, and ability to address, the needs of individuals with co-occurring addictive and mental health disorders.

Specific Recommendations:

a. Identify and/or train key facilitators for integrated team management within or across program services.

b. Provide joint training for staff of substance abuse and mental health providers (e.g., in-services, grand rounds, case conferences).

c. Reimbursement sources should require training for integrated services for co-occurring disorders.

d. Provide training to staff in preparation for changes that will mandate integrated treatments.

e. Stress the need for skills in co-occurring assessment and referral for clinical staff that are unable to develop treatment skills for this population.

4. **General Principle**—Licensing, Accreditation, and Credentialing Standards

Licensing, accreditation, and credentialing standards should be used to influence improvements, ensure quality, or promote changes in practice. Minimum standards should be required for diagnosis and treatment of substance abuse, mental health, and co-occurring disorders. Professional organizations, regulatory agencies, and licensing bodies should be responsible for developing standards and minimum requirements for diagnosis and treatment of these disorders, and for determining pay for providers from various disciplines according to the clients' need for expert care.

Specific Recommendations:

a. Licensing, accreditation, and credentialing bodies should work with professional groups to make the content of substance abuse and mental health issues a preservice and continuing education requirement for each field.

b. Training regarding special populations of individuals with co-occurring disorders should be included in standards.

5. **General Principle**—Criminal Justice Populations

Jails, prisons, and probation and parole programs should be required to develop clinical, educational, and training programs similar in scope and depth to the standard of care for the general populations. (**Note:** Although the group considered the need for criminal justice services to be great, there was no representation from individuals working in the criminal justice system when the actual recommendations were developed.)

Specific Recommendations:

a. Training and educational programs should be developed to meet the enormous need to diagnose and treat addictive, mental health, and co-occurring disorders in corrections populations.

b. Federal, State, county, and municipal governments should mandate minimum level of training for clinical staff who diagnose and treat substance-related, mental, and co-occurring disorders in the justice system.

Chapter VI: Homelessness

Are co-occurring substance-related and mental health disorders a major cause of homelessness? How does homelessness affect treatment?

Many homeless individuals—who both suffer greatly and impair the quality of life of their families and communities—often represent the end of a long line of failed attempts to treat their numerous co-occurring substance-related, mental health, and health disorders. Other homeless persons with multiple disorders have never been treated. Society ignores the homeless at its own risk; unless prevention, treatment, and rehabilitative services break the cycle, the multigenerational problem of the homeless will broaden its impact on the larger society. For example, one survey of 202 residents of New York City shelters reported the following:

- 23% reported that they were abused as children,
- 16% reported heavy use of alcohol and/or drugs in their childhood home,
- 61% of the men reported being fathers,
- 73% of the women reported being mothers.[88]

The problems of co-occurring substance-related and mental disorders among the homeless are not limited to our large cities. A 1995 survey of the sheltered homeless population of two rural counties concluded that mental illness and substance abuse were major problems. About one-third reported a psychiatric hospitalization, one-third reported a suicide attempt, and an estimated 60% had a drug abuse or dependence problem.[89]

It is estimated that one-third of homeless persons are severely and persistently mentally ill, and 10–20% of the homeless are severely mentally ill and have substance-related disorders.[90] Additional members of the homeless population have co-occurring substance-related and mental health disorders, but are less severely mentally ill.

The homeless have often been labeled "treatment resistant." However, those who work with this population note that they often resist treatment they view as irrelevant. Their immediate goal may be food and safe shelter. After basic needs are met, they may be interested in treatment of the conditions they view as less pressing: their substance use and their psychiatric symptoms.

Special Needs: SAMHSA is mandated to focus attention on special needs populations, such as women, ethnic minorities, seniors, children and adolescents, Native Americans, immigrants, the poor, persons infected with HIV, and, of course, the homeless. Each of the special needs populations is overrepresented among the homeless. Numerous studies

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[88]The New York Times, 11/4/91.

[89]Kales, J.P., Barone, M.A., Bixler, E.O., Miljkovic, M.M., Kales, J.D. Mental illness and substance abuse among sheltered homeless persons in lower-density population areas. Psychiatric Services 1995; 46(6): 592–595.

[90]Drake, R.E., Osher, F.C., Wallach, M.A. Homelessness and dual diagnosis. American Psychologist 1991; 46(11): 1149–1152.

have demonstrated that many chronically homeless persons are both mentally ill and substance abusers.[91] Whatever their age, they typically have a history of mental health and/or substance abuse problems since childhood or adolescence.

Supported by a National Institute on Drug Abuse grant, Rahav[92] and colleagues studied a large group of homeless, severely mentally ill, substance-abusing men in New York City. After intake, they were randomly assigned to a therapeutic community that was designed to provide integrated treatment or to a community residence that provided parallel, collaborative treatment. Comparing clients who remained in treatment for at least 1 year, the therapeutic community appeared to be more effective in reducing depressive, psychotic, and functional symptoms, and in helping residents to remain abstinent from drugs.

In another set of findings, the Rahav report notes, as do other reports, that the men studied came from poor, deprived, and abusive childhood homes in which drug and alcohol abuse were prevalent. Criminal behavior was frequent among their parents, and a majority of these chronically mentally ill and addicted men have themselves been involved with the criminal justice system.

Substance abuse services have traditionally focused on meeting the needs of mainstream men, while traditional mental health services have focused on mainstream men and women. Most research has been done primarily on white, middle-class men. As a result, both research data and treatment protocols have inadequately addressed persons with special needs, including homelessness.

Two reports issued in 1995 by the Department of Health and Human Services Inspector General followed up on the National Co-morbidity Survey by surveying several programs that were expressly created to provide comprehensive and integrated treatment to persons with co-occurring substance-related and mental health disorders. The reports note that clients being served in the programs surveyed *usually* have other serious social, medical, and financial problems; often belong to a minority group; often come from a family of disadvantage; often have a personal history of trauma; and often have minority status. Many clients served in these programs have been homeless, and almost all are at risk of becoming homeless in the future.

The Vietnam Veterans of San Diego reports promising early results from their CSAT-funded program for homeless veterans with co-occurring substance-related and

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[91]Belcher, J.R. On becoming homeless: A study of chronically mentally ill persons. Journal of Community Psychology 1989; 173–185.
Drake, R.E., Wallach, M.A., Hoffman, S.J. Housing instability and homelessness among aftercare patients of an urban state hospital. Hospital and Community Psychiatry 1989; 40: 46–51.
Drake, R.E., Wallach, M.A., Teague, G.B., Freeman, D.H., Paskus, T.S., Clark, T.A. Housing instability and homelessness among rural schizophrenic patients. American Journal of Psychiatry 1991; 148: 330–336.
[92]Rahav, M., Rivera, J.J., Nuttbrock, L., Ng-Mak, D., Sturz, E.L., Link, B.G., Struening, E.L., Pepper, B., Gross, B. Characteristics and treatment of homeless, mentally ill, chemically-abusing men. Journal of Psychoactive Drugs 1995; 27(1): 93–103.

mental disorders. After an initial phase focused on education and treatment for both disorders, the second phase focuses on readiness for employment. Six months after leaving the program, either by completion or premature departure, 42% were employed. Only 14% were employed before entering the program.[93]

In recent years, targeted Federal programs such as Projects for Assistance in Transition from Homelessness have focused on the special population of the homeless with severe psychiatric disorders. The Center for Substance Abuse Treatment (CSAT) has led the way toward focusing Target Cities and other grants on special populations of substance abusers, including those with co-occurring mental health disorders. Persons with co-occurring substance-related and mental health disorders who are in jails and prisons have been another CSAT target population. However, despite these important beginnings, the problems of homeless individuals with co-occurring substance-related and mental health disorders must be a focus of the developing SAMHSA policy initiative.

[93]Center for Substance Abuse Research Fax, 1996; 1: Issue 13.

Recommendations of the Homelessness Track

Preamble: A fundamental need in adequately addressing the problems of homeless people with co-occurring substance-related and mental health disorders is additional funding. However, mindful of the budgetary situation now being faced by Federal agencies, we have chosen to focus our recommendations on reallocation of existing funding and on improved efficiencies at the national, State and local levels, which we believe will result in more and better assistance to homeless people. This in no way implies that additional funding is not required.

We believe that in the coming few years, States and localities will be looking for ways in which to redesign their service and housing systems to assume newly "devolved" responsibilities. While funding and Federal directives may be under attack, this desire of States/localities for assistance presents us with an opportunity that must be addressed by SAMHSA.

Incentives to Improve Assistance

- Establish an incentive pool that will go to States/localities that do integrated planning for vulnerable populations that include those with co-occurring substance-related and mental health disorders. Integrated planning should include planning to meet not only the substance abuse and mental health treatment needs of vulnerable people, but also their housing, income, and other service needs.

- Give States that successfully accomplish integrated planning (as defined above) increased flexibility on the categorical restrictions to block grant funds.

Other Measures to Improve Assistance

- SAMHSA should clearly state that treatment of individuals with co-occurring substance-related and mental disorders, especially those in vulnerable populations, is a priority of DHHS.

  — Carve out funding streams that can be used to address the needs of special populations (such as the homeless) who have multiple diagnoses.

  — Block grant recipients should be required to specifically and adequately address the needs of homeless people with co-occurring disorders in their planning efforts and to dedicate resources to meet the needs of this population.

- SAMHSA should establish a core objective related to vulnerable populations that have co-occurring substance-related and mental disorders.

  — In order to accomplish this, SAMHSA should establish a management information system that collects data on this population, including its size;

service, income, and housing needs; service, income, and housing resources available to it; and outcome data.

Services Available to Homeless People and the Technical Assistance and Training Needed to Improve Them

Currently, homeless people are served largely by nonprofit organizations. They coordinate housing, service, and income assistance.

- The nonprofit service/housing delivery model, with which SAMHSA is familiar through its research and demonstration programs, should be promulgated to States and localities through the establishment of a SAMHSA technical assistance (TA) program. This program should include at least the following:

  — publications;
  — local or regional TA conferences/trainings;
  — establishment of a pool of provider experts who can deliver TA; and
  — development of TA capacity within the SAMHSA staff.

- Nonprofit providers/housers and homeless/formerly homeless people should be given the tools they need to participate in State and local planning.

  — Make such participation one criterion for incentive grants (see previous recommendation on financial incentives).

  — Require that States establish a technical advisory group to assist with planning—the group should be at least 51% nonprofit/consumer.

- In order to increase nonprofit capacity, assess the TA needs of nonprofit providers for management, compliance, evaluation, certification, staffing, etc., and design a TA component in SAMHSA that addresses these needs.

NOTE: In this time of scarce resources, it may be necessary to use research/ demonstration funds to pursue the implementation of the findings of research/ demonstration programs rather than to continue planned research and demonstrations.

- Make adjustments in the mainstream programs that will allow them to assist homeless people with co-occurring disorders. Some of the considerations to be addressed are listed below. While it may not be possible to mandate all of these changes at the State/local level, the mainstream programs (block grants) should allow and encourage these types of assistance rather than make it difficult to implement them or impose disincentives for doing so.

— Carve out funding for vulnerable populations.

— Enhance outreach efforts.

— Establish performance standards, but make sure that they are not a disincentive to serving those who are difficult to serve or require numerous services.

— Take the treatment needs of clients' families into account.

— Be culturally sensitive.

— Address the housing, income and other service needs of clients—this should include their HIV/AIDS or other health-related needs, their domestic violence history, and their social relationships.

— Housing needs of other family members must be addressed when the client is in residential treatment (this is particularly important for children of single parents).

— Both urban and rural programming must be accommodated.

— Consumers must be involved in planning their own treatment.

- Once the mainstream programs have been adjusted to accommodate issues such as these, SAMHSA should undertake a technical assistance effort, based on the information it has from research and demonstration programs, to share information on models and best practices with the States and localities. This should include at least the following components:

  — publications;

  — local or regional technical assistance conferences or trainings;

  — establish a pool of provider experts for TA; and

  — development of an in-house TA capacity.

Finally, we encourage DHHS to take the lead with other Federal agencies to ensure that Federal programs can meet the needs of homeless people with co-occurring substance-related and mental health disorders.

- Secretary Shalala should convene an interagency conference on the issue of integration of services, housing, and income issues for those with co-occurring disorders.

- Federal agencies should be encouraged to coordinate their programs so that they can be sensibly combined to address the needs of vulnerable populations with dual diagnoses at the State and local levels.

Chapter VII: Criminal Justice

What is the nature of the association between crime and co-occurring substance-related and mental health disorders? Why is the highest frequency of co-occurring disorders found in criminal justice settings?

As will be demonstrated in this chapter, a majority of the exploding numbers of incarcerated individuals have co-occurring substance-related and mental health disorders.

In the past 25 years the United States has greatly expanded its jail and prison capacity. The total population of those incarcerated in 1972 was about 200,000. On December 25, 1995, the *New York Times* cited figures from the Bureau of Justice Statistics of the Department of Justice. The Bureau counted 1.5 million individuals in State and Federal prisons in June 1995, an increase of nearly 90,000 from the prior year. The Bureau estimates an additional 500,000 people are incarcerated in local jails, resulting in a total of about two million individuals currently serving sentences or awaiting trial in jail or prison.

The growth in incarceration for women with drug-related offenses in recent years has exceeded the rate of increase for men. Between 1986 and 1991, the number of women in State prisons for drug-related offenses increased 433 percent, compared with an increase of 283 percent for men. By the beginning of 1996, there were 69,028 women in State prisons.[94]

The general trend seen in the 1992 National Co-morbidity Survey data indicates that the typical age of onset for meeting the criteria for a DSM-III-R mental disorders is about 11, and the age for meeting criteria for substance-related disorders is between 17 and 21. However, there is evidence that age of onset may be different for children from special populations, such as the poor, the homeless, members of ethnic minorities, and those in the criminal justice system. For example, 1994 data from Washington, DC, indicate that a majority of arrestees under 18—most of whom are from poor, African-American backgrounds—are using street drugs at the time of their arrest. Few of these arrests are because of simple drug use. Some arrests are related to illegal drug trade activities, but juvenile arrests for all causes are included in the study. (More information on the cause of juvenile arrests is offered below.) The percent of juvenile arrestees testing positive for drugs increases with age, rising to 75% by age 17. A majority of adolescent arrestees in their early teens are already using illicit drugs.[95]

On September 8, 1995, the *New York Times* cited a Justice Department report that noted a 100% jump in arrest rates for violent crimes among juveniles, aged 10 to 17, between 1983 and 1992. The report also noted that between 1984 and 1993 the number of homicides among juveniles involving handguns increased 500%. The homicide rate

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[94]LeBlanc, A.N. A woman behind bars. The New York Times Magazine 1996; June 2: 35–38.
[95]Center for Substance Abuse Research Fax, 1995; 4: Issue 30.

among 14 to 17 year olds increased 165% in the past 10 years. Professor Alfred Blumenstein of Carnegie Mellon University noted recently that the greatly increased rate of gun-related homicides committed by juveniles "...appear[s] to be linked to the recruitment of juveniles into the illegal drug trade and the consequent diffusion of guns from them to a much larger number of young people."[96]

In 1990 the National Institutes of Mental Health estimated from Epidemiological Catchment Area Study data that 82% of prison inmates had a lifetime history of mental health disorder, and 81.6% of this group also had a substance-related disorder.[97] In 1990, Chiles and colleagues published a report indicating that 56% of Washington State offenders had a lifetime history of depression, bipolar disorder, schizophrenia, or another psychotic disorder. Forty-four percent had antisocial personality disorder. These researchers also note that alcohol and drugs are available to inmates in many jails and prisons, making drug abuse treatment even more necessary.[98]

Kupers has recently pointed out that today's overcrowded prisons are institutions that may be causing mental disorder in prisoners.[99] The constant threat of violence; racial strife; crowding; inadequate mental health treatment; and reduction in rehabilitative, vocational and educational activities have led to what Kupers believes is a traumatizing environment that probably causes new cases of stress response syndrome and exacerbates existing cases of post-traumatic stress disorder. To cite a specific example, one study estimates that 20% of prisoners are raped.[100]

Some of the same changes that have contributed to the increase in the criminal justice population in the past 20 years appear also to be causative of the increase in the number of individuals with co-occurring disorders. Deinstitutionalization, the increased availability of inexpensive illicit drugs, and the decrease of adequately paid low-skill jobs may be offered as examples. It is important to note that studies demonstrate that the substance-related and mental disorders **precede** entry into jail and prison.[101]

Similar to nonincarcerated populations, severely mentally ill prisoners have an excessively high rate of co-occurrence with substance-related disorders. In a 1991 study of male detainees at the Cook County (Chicago) Jail, 85% of prisoners who were severely

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[96]Blumenstein, A. Youth violence, guns, and illicit drug markets. National Institute of Justice Research Preview 1996; June: 1–3.

[97]Regier, D.A., Farmer, M.E., Rae, D., Locke, B.Z., Keith, S.J., Judd, L.L., Goodwin, F.K. Comorbidity of mental disorders with alcohol and other drug abuse. Journal of American Medical Association 1990; 246(19): 2511–2518.

[98]Chiles, J.A., Von Cleve, E. Jemelka, R.P., Trupin, E.W. Substance abuse and psychiatric disorders in prison inmates. Hospital and Community Psychiatry 1990; 41: 1132–1134.

Cote, G., Hodgins, S. Co-occurring mental disorders among criminal offenders. Bulletin of the American Academy of Psychiatry and Law 1990; 18: 271–281.

[99]Kupers, T.A. Trauma and its sequelae in male prisoners: Effects of confinement, overcrowding, and diminished services. American Journal of Orthopsychiatry 1996; 66(2): 189–196.

[100]Polych, C. Punishment within punishment: The AIDS epidemic in North American prisons, Men's Studies Review 1992; 9: 13–17.

[101]Robins, L.N., Regier, D.A. Psychiatric Disorders in America: The Epidemiological Catchment Area Study. New York: Free Press, 1991.

mentally ill also abused alcohol, and 58% abused illicit drugs. The comparable numbers for those who were not severely mentally ill were only 48% and 30%.[102]

Co-occurring substance-related and mental disorders may cause declining social and functional status, which may lead or contribute to criminal behavior. This may describe an important association between co-occurring disorders and criminal behavior.[103] If so, it is reasonable to assume that successful early intervention, treatment, and rehabilitation of co-occurring disorders may decrease crime.

Based on data noted above from the ECA, from Chiles, and from Cote, a simple calculation indicates that more than one million prisoners have co-occurring substance-related and mental health disorders.[104] While detailed studies are not readily available, it is likely that similar ratios hold for the several million individuals who are on parole or probation; they are the unincarcerated portion of the criminal justice population. The majority of individuals with criminal justice system status who have co-occurring or single disorders are untreated. For example, a 1996 report from Drug Strategies notes that:

> "Less than 10% of Federal inmates who are addicted have treatment available to them, despite the fact that research over the past decade confirms that intensive prison treatment programs can reduce recidivism by half after release."[105]

The bulk of new funds for the criminal justice system go to construction of new jails and prisons and to corrections officers, not to increased treatment staff. Many prisons have greatly increased their census without increasing their counselors, doubling or tripling the number of prisoners per counselor. Departments of corrections are now turning to the use of contracts with private managed care companies to provide treatment services. This may produce a new set of problems to be solved.

The same situation holds for parole and probation officers, whose caseloads may number in the hundreds. Such officers, if given training and reasonable caseloads, can often function as case managers and help individuals access treatment. When caseloads are excessively large, such vital services are unavailable to most probationers and parolees.

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[102]Abram, K.M., Teplin, L.A. Co-occurring disorders among mentally ill jail detainees. American Psychologist 1991; 46(10): 1036–1045.

[103]Pepper, B. Interfaces between criminal behavior, alcohol and other drug abuse, and psychiatric disorders. Center for Substance Abuse Treatment. Treatment Improvement Exchange Communique. 1993; Spring: 5–7.
Test, M.A., Knoedler, W., Allness, D., Burke, S. Characteristics of young adults with schizophrenic disorders treated in the community. Hospital and Community Psychiatry 1985; 36: 853–858.
Yesavage, J.A., Zarcone, V. History of drug abuse and dangerous behavior in inpatient schizophrenics. Journal of Clinical Psychiatry 1983; 44: 259–261.

[104]Pepper, B., Massaro, I. Trans-institutionalization: Substance abuse and mental illness in the criminal justice system. Tie-Lines 1992; 9(2): 1–4.

[105]Center for Substance Abuse Research Fax, 1996; 5: Issue 13.

Correctional treatment staff are increasingly overburdened. In addition, most have been trained to treat drug abuse **or** mental disorders. Upgraded training for the treatment of substance abuse has been urged and supported with technical assistance and publications for the past several years by the Center for Substance Abuse Treatment of SAMHSA. This assistance has often broadened its focus to include the treatment needs of individuals with co-occurring substance-related and mental disorders. While this start has been made,

> Most of the mental health and substance abuse treatment personnel in the criminal justice and corrections systems will require upgraded training and powerful administrative support before they can carry out their mission for the 1990's.[106]

SAMHSA is mandated to focus attention on special needs populations, such as women, ethnic minorities, seniors, children and adolescents, Native Americans, immigrants, the poor, the homeless, persons infected with HIV, and others. Each of these special groups tend to be overrepresented in the criminal justice population. For example, a report from the Bureau of Justice Statistics of the Justice Department was covered on page one of the *New York Times* on October 28, 1994. It noted that

> At the end of 1993 1,432 blacks out of every 100,000 blacks in the country were in prison, more than seven times the 203 white inmates for every 100,000 whites in the country.

Substance abuse services have traditionally focused on meeting the needs of men, while traditional mental health services have focused on mainstream men and women. Research has been done primarily on white, middle-class men. As a result, both research data and treatment protocols have inadequately addressed persons with special needs relating to gender, ethnicity, cultural diversity, and legal status. Prisoners have infrequently been the focus of research.

In recent years, CSAT has focused grants on special populations of substance abusers, including those in jails and prisons. The Center for Mental Health Services has joined CSAT in some of these efforts. However, it is clear that the current efforts of SAMHSA and its component centers must be greatly augmented if the growth of the criminal justice population with co-occurring substance-related and mental disorders is to be curbed.

Pepper has noted that three public system paradigms—substance abuse treatment, mental health treatment, and corrections—have developed separately, at different times in history, in response to quite different needs. At the present time, however, the three populations of these separate systems have flowed together to a significant degree. The result is a new population of multineed, multisystem clients who have earned an admission ticket to each of the three systems. However, not one of the three can adequately treat them while meeting society's need for protection. Therefore, a new

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[106]Pepper, B. Interfaces between criminal behavior, alcohol and other drug abuse, and psychiatric disorders. Center for Substance Abuse Treatment; Treatment Improvement Exchange Communique. 1993; Spring: 5–7.

paradigm must be created. Such a community-client protection system must provide community protection at the same time that it treats co-occurring substance-related and mental disorders in a carefully constructed continuum of services.[107]

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[107]Pepper, B. A Community-Client Protection System (CCPS) for the 21st Century. Tie-Lines 1995; XIII (2): 7–9.
Pepper, B., Massaro, J. Trans-institutionalization: Substance abuse and mental illness in the criminal justice system. Tie-Lines 1992; 9(2): 14.
Pepper, B., Albert, N., Ryglewicz, H. The multi-need/multi-system client: A confluence of variables. Tie-Lines 1993; X(2): 1–6.
Pepper, B. Interfaces between criminal behavior, alcohol and other drug abuse, and psychiatric disorders. Center for Substance Abuse Treatment, Treatment Improvement Exchange Communique 1993; Spring: 5–7.

Recommendations of the Criminal Justice Track

Premise: SAMHSA shall recognize, and require the States to recognize, the population of individuals with co-occurring substance-related and mental health disorders, and shall address the needs of this population in a way that proportionately reflects the profile of the population.

Incentives

- Provide financial incentives for planning integrated systems at the State/local levels.

- Remove categorical (current) restrictions to allow more flexibility and encourage States to provide flexibility in program certification standards.

What support can the Federal Government offer?

- Reinforce support that the criteria developed by the American Society of Addiction Medicine should recognize the biosocial needs of the co-morbid patient in the patient placement criteria for assessment, treatment planning, treatment duration, and aftercare in discharge planning for managed care programs.

- In performance-based contracting with States, establish a core objective that addresses services (integrated) to the dually diagnosed population.

- Conduct a co-morbidity survey of the criminal justice population.

- SAMHSA provides models of the use of national co-occurring data for States for planning, justification for funding allocations, and addressing outcome studies related to relapse incidence and treatment duration.

- Encourage and assist development of a management information system that collects data on those with co-occurring disorders to ensure accurate capture of the characteristics as well as the count of this population.

- Encourage States to include clients and providers in the planning process to develop a comprehensive, integrated approach that addresses issues of self-sufficiency (employment, housing) and identifies measurable outcomes (vocational).

The group consensus is that offensive language and bias related to criminal justice personnel should be removed as it continues the barriers to positive effective collaboration.

Improve Criminal Justice Services

- Encourage criminal justice systems to actively identify the co-morbid population within their systems to add to their existing current data.

- Identify the gaps that currently exist in the criminal justice system (prison, jails, probation, and parole) and support additional programs to support gaps in services to individuals with co-occurring disorders.

- Expand services by encouraging funding entities to begin looking at common populations and dialogue on funding strategies that work on the local level.

- SAMHSA should provide a message on what works (e.g., using the Access to Community Care and Effective Services and Supports model) and disseminate information on model prison, community corrections, and jail-based treatment programs funded by CSAT to appropriate individuals and organizations.

- SAMHSA should make stronger liaisons with the American Jail Association, the American Correctional Association, the American Probation and Parole Association, the National Institute of Corrections, and the Bureau of Justice Affairs.

Special Treatment Considerations and Training Needs

- Provide technical assistance and resources to train service providers who must address cultural and gender-specific characteristics. Training shall also include necessity of sensitivity to the cultural environment of security facilities.

- Provide cross-training of professionals in joint sessions.

- SAMHSA should work with the Department of Justice on the portion of the Crime Bill that address substance abusers with mental health issues.

General Recommendation

SAMHSA should create an organizational unit responsible for combined services. Such a unit would recognize and legitimatize the dually diagnosed populations and serve as a funding source and provide expertise, technical assistance, and training to the field. Substance Abuse and Mental Health should each give 2.5% of their budgets to such an entity.

Chapter VIII: Financing and Managed Care

Will the new methods of financing health care, such as managed care, help or hurt treatment for co-occurring substance-related and mental disorders? As we spend less, can we still hope for better results?

Rapid changes in health care financing and delivery are taking place in reaction to the great increase in health care costs over the past few decades. These cost increases have created an economic crisis, threatening the Nation's productivity when compared with other producer nations with far less expensive health care systems. A National Strategy must seek to ensure that persons with co-occurring substance-related and mental health disorders will be benefited, not harmed, by new funding mechanisms for health care.

During the past 200 years, the Federal and State governments have created numerous agencies and funding streams to deal with problems of criminal behavior; mental disorders; alcohol abuse; and substance abuse. Construction of jails began about 1790; the era of public mental hospitals began in 1845. Publicly funded programs for the treatment of alcohol abuse and, later, substance abuse were developed within the past 30 years.

Separate agencies for discrete categories of individuals, based on historic precedent, continue to be the rule, despite the growth of the population of individuals with co-occurring disorders. As a consequence, programs that seek to serve persons with co-occurring disorders must seek the support of multiple funding streams.

To make matters more complex, an agency that is providing funding for one disorder may prohibit activities that are essential for the program to be effective; to receive funding from another agency; to be additionally licensed by another agency. For example, a mental health agency may, concerned for the privacy of a mental health client in a dual diagnosis residential program, prohibit drug searches of residents' rooms. However, these "intrusive acts" may be therapeutic community activities, which are at the core of residential substance abuse treatment.

The entire system of health funding is now in the process of rapid change, as all payors—both public and private—are responding to increased costs by adopting new arrangements to limit, control, and manage care.

Managed care is an umbrella term that encompasses many different meanings. In general, it refers to any payment arrangement for health care in which unlimited fee-for-service payments are avoided. Since minimally monitored fee-for-service has been the traditional form of payment, managed care often represents a radical change. The managed care organization's task is to

> ...act as agent for the payor and to manage the relationships between payors, providers, and consumers. In each relationship, we have identified many challenges for managed care including the complexity of public

financing, the vulnerable nature of the population served, and the importance of synchronization between managed care performance and community expectations for the public mental health system.[108]

A presidential initiative designed to provide universal national health insurance and a uniform method of managing care was unsuccessful in 1992. This left the way open for a wide variety of initiatives by State governments, private insurers, employers, and providers, each developing their own methods of managing the costs of health care. These initiatives range from gatekeepers limiting access to specialists, all the way to fully capitated arrangements. In capitation the provider is paid a flat fee per enrolled member per month. In the first instance the gatekeeper for the payor must limit access to care in order to keep costs lower than premiums. Under capitation, the provider, as the bearer of risk, must self-manage and limit care in order to maintain solvency.

Managed care companies, including Health Maintenance Organizations (HMOs) have been developing in the private sector for several decades. They have gained a great deal of experience in providing health care to relatively young and healthy populations of the employed and their families, with premiums being paid by employers. HMOs and managed care companies have had relatively little experience in providing health care for poorer, more severely ill individuals and families. Until recently, public agencies have cared for and borne the costs for this sicker and costlier population, often by purchasing services within the fee-for-service system. Now, however, many public agencies are turning to managed care companies to provide health care and manage costs for the elderly, the poor, the severely and persistently ill, and the disabled, including those with co-occurring disorders. Concerns have arisen because

- Managed care companies have a great deal of experience in controlling costs by providing time-limited care for acute illnesses. They have little experience in providing continuing care for severe and persistent disorders.

- Managed care companies have controlled costs by focusing on the use of primary care doctors and nurses, and minimizing the use of specialists, such as those who have been trained to treat substance-related and mental disorders.

- Most primary care providers are not trained or experienced in providing care to severely ill, impaired individuals with co-occurring substance-related and mental health disorders.

Some managed care companies, recognizing the interrelationship between substance-related and mental health disorders, have carved out the area of behavioral health from the general health sector. These companies contract separately with behavioral health providers, and usually require the provider to serve both the mental health and the substance abuse needs of the client population, but not necessarily in an

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[108]Cuffel, B.J., Snowden, L., Masland, M., Piccagle, G. Managed care in the public mental health system. Community Mental Health Journal 1996; 32(2): 109–124.

integrated manner. Other managed care arrangements "carve in" treatment for substance-related and mental health disorders; that is, include substance abuse and mental health treatment within the general provision of health care.

While many pilot, experimental, and new managed care arrangements are being tried out all over the Nation, there is not yet a sufficient body of knowledge and experience that can be used to evaluate objectively the outcomes of these new programs.

Most experts believe that all funding for health care, including for individuals with co-occurring substance-related and mental health disorders, will move in the direction of managed care, with discounted fee-for-service and capitation as the two dominant payment mechanisms.

Recent estimates indicate that in any 12-month period there are 48 million individuals over the age of 18 with at least one mental health or substance-related disorder which meets DSM-III-R criteria. Within that group, there are 11.4 million who are seriously mentally ill (SMI), and 5.4 million who are seriously and persistently mentally ill (SPMI).[109] No comparable estimates are available for children and adolescents under 18 years of age.

Traditionally, care for the SMI and SPMI populations has been publicly funded, and the care itself has often been provided by salaried employees of public or nonprofit private agencies. Most States are giving serious consideration to switching provision to private providers who are managed by private managed care companies.[110] Many State, county, and municipal agencies have already done so, with mixed results. To date, accreditation bodies have not adequately addressed quality of care and outcome issues regarding co-occurring substance-related and mental disorders.

In response to the issues noted above, SAMHSA has contracted with the Institute of Medicine of the National Academy of Sciences to do a study on **quality assurance and accreditation guidelines for managed behavioral health care.**[111] The report was scheduled for release in October 1996. It should provide a useful progress report on how managed care and accrediting organizations are moving forward to provide care and outcome information about various forms of payment and service delivery for co-occurring substance-related and mental disorders.

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[109]State Mental Health Plans. GAO HRD-90-142. Washington, DC: General Accounting Office.
[110]Essock, S.M., Goldman, H.H. States' embrace of managed mental health care. Health Affairs 1995; 14(3): 34–49.
[111]Edmunds, M. Study Director, Committee on quality assurance and accreditation guidelines for managed behavioral health care, Institute of Medicine, National Academy of Sciences.

Recommendations of the Financing and Managed Care Track

The financing track workgroup was charged with developing recommendations for actions that would be incorporated into a national strategy to improve services and client outcomes for persons with co-occurring mental and addictive disorders. The group examined several major problem issue areas and attempted to develop recommendations, along with, in some instances, the necessary action steps to implement the recommendations.

The five issue areas were

- identifying how much money was being spent on persons with co-occurring mental and addictive disorders;
- identifying the source of the funding and the implications of separate funding streams;
- identifying how the funds could be better focused and where additional funds were needed;
- identifying what a model managed care system for persons with co-occurring disorders would look like; and
- identifying what mechanisms should be used to ensure accountability.

How Much Funding?

Problem: The primary problem that the workgroup sought to address was the lack of reliable information and an accurate accounting of how much money is actually being spent on persons with co-occurring disorders.

1. Recommendation:
   Establish an accounting of how much money is spent on persons with MH/SA problems. Include cost shifts to the welfare system, criminal justice, education, etc.

   Action Steps:

   — Update the Dorothy Rice 1985 Study on the "Economic Costs of Alcohol and Drug Abuse, and Mental Illness" to society.
   — Include data on co-occurring disorders in the SAMHSA Center for Substance Abuse Treatment and Center for Mental Health Services data analysis project.

2. Recommendation:
   Establish cost benchmarks against which we can measure how much money is necessary to ensure services (e.g., a capitated rate that allows for adequate services).

   Action Step:

   — Compile and analyze information from studies (including international ones) of estimates of funds necessary to ensure adequate care.

3. Recommendation:
   Establish a common methodology for cost accounting.

   Action Steps:

   — Review Milliman and Robertson Studies on costs of providing mental health and substance abuse services.
   — Examine and follow up on current CSAT/CMHS initiative on unit costs.

4. Recommendation:
   Identify the characteristics of the population receiving services, and determine the percent of persons who are not receiving services.

From Whom?

Problem: The workgroup examined two issues: (1) what is the source of funds for services for persons with MH/SA problems and (2) how can problems created by separate funding streams be addressed (e.g., benefits and services are bifurcated, a lack of interest in serving persons with co-occurring disorders, stigma, etc.).

1. Recommendation:
   Encourage the blending of funds under managed care plans for persons with co-occurring disorders. (Managed care systems provide an opportunity to integrate funding streams and support the flexible use of funds.)

   Action Steps:

   — Ensure that plans and networks have adequate capacity.
   — Identify and rationalize sources of funding in the private and public sector.
   — Provide incentives for blending of funds.
   — Identify and rectify sources of bifurcation.

2. Recommendation:
   MH/SA providers should explore the possibility and feasibility of tapping into other sources of funding.

   Action Steps:

   — Investigate the following sources of funding:
   — Hospital district tax (Florida)
   — Criminal justice system
   — HUD (e.g., Safe Affordable Housing, Safe Haven, McKinney Program)
   — Transportation
   — Education
   — Tobacco and liquor taxes (excise taxes)
   — Excise tax on profits of related expenditures
   — Drug asset forfeiture funds
   — Encourage tax incentives for corporations who provide a model benefit plan
   — Block grant funds
   — Utilize MH/SA funds for persons with co-occurring disorders

How Spent?

Problem: The workgroup next identified several areas where additional attention to specific issue areas relating to co-occurring disorders would be most beneficial.

Recommendations:

1. Support funding for training of multiskilled providers in rural areas.
2. Support funding and criteria development for "aggressive" case management.
3. Patient co-pays, deductible, etc., should not be economically biased and the process for determining self-pay should include consumer input.
4. Consumers should be involved in managed care applications, benefit design, and service systems.
5. Examine issues unique to small businesses (e.g., premiums).
6. Develop standards in contracts for access, early intervention, integrated treatment, continuing care, and outcomes. Define expected outcomes and make services explicit in the contract.
7. Support wraparound and other supportive services.
8. Prepare consumers for a differently financed system.
9. Develop a report card for the care of persons with co-occurring disorders based on acceptable minimum and optimal standards.

Impact of Managed Care Results:

Problem: The workgroup then identified several elements of a model managed care system for persons with co-occurring disorders

Managed care systems should meet the following standards:
— Define most appropriate sector and provider of care for prevention, treatment, and rehabilitation.
— Base expenditures on likely preventive impact (e.g., aggressive early intervention and treatment if primary care physicians are to prevent substance abuse).
— The system should have an adequate number of cross-trained staff to provide integrated treatment.
— There should be flexible expenditure of funds to support, for example, housing, vocational rehabilitation, etc.
— Interventions for high-risk youth need to be validated.
— Regulations to limit percent of dollars spent on administration.
— There should be appropriate funding for collateral treatment.
— There is a great need to assure continuity of care.

Accountability:

Problem: Finally, the workgroup addressed three additional issues: (1) lack of prevention services; (2) lack of services for the most seriously ill patients, and (3) how to hold managed care organizations accountable for providing comprehensive and high-quality services to persons with co-occurring disorders.

1. Recommendation:
   Provide incentives for prevention.

   Action Steps:

   — Demonstrate the cost-effectiveness of preventive services.
   — Provide financial incentives for supporting prevention.
   — Support legislative mandates to encourage the provision of preventive services.

2. Recommendation:
   Provide continuity of care to high-risk patients in treatment.

   Action Step:

   — Develop special per capita risk adjustment for high-risk patients.

3. Recommendation:
   Eliminate disincentives to disenroll, and provide for incentives for the recognition, treatment, and rehabilitation of patients in the general medical system, and for improved treatment outcomes.

   Action Steps:

   — Fund special studies to look at issues of access and various gatekeeper mechanisms.
   — Support government mandates against disenrollment.
   — Impose sanctions.

4. Recommendation:
   Support efforts to hold managed care organizations accountable for the care that they provide.

   Action Steps:

   — Ensure that there is an adequate grievance and appeals process.
   — Ensure uniform data reporting, including information on the number of people denied treatment.
   — Develop Federal standards for managed care organizations (MCOs).
   — Identify a minimum core set of services.
   — Ensure adequate Medicaid/Medicare funding levels.

Lastly, the group identified several key outcomes, to be based on meaningful indicators such as continuity, functional status, and quality of life, if these recommendations are to be meaningfully implemented:

- An improvement in functional impairment (activities of daily living, instrumental activities, increased hope, etc.);
- Cost-offsets in general health care, criminal justice system, etc.;
- Adequate epidemiologically defined penetration rates;
- Reduced reoccurrence rates;
- Increased provider capacity for these populations;
- Increased access to different treatment modalities;
- Reductions in costly rehospitalization rates;

- Reduced overuse of acute care in emergency rooms; and
- Reductions in the length of hospital stays by using procedures that quickly stabilize the patient.

Appendix A

The Conference Agenda

Substance Abuse and Mental Health Services Administration

IMPROVING SERVICES: Co-Occurring Substance Abuse and Mental Health Disorders
Georgetown University Conference Center
November 13–14, 1995

AGENDA

Monday, November 13:

8:00 AM **CONTINENTAL BREAKFAST AND REGISTRATION**
South Gallery

9:00 **WELCOMING REMARKS**
Grand Ballroom H

Nelba Chavez, Ph.D., Administrator, Substance Abuse and Mental Health Services Administration (SAMHSA)
Max Schneier, J.D., SAMHSA National Advisory Council
Ford H. Kuramoto, D.S.W., SAMHSA National Advisory Council

9:30 **KEYNOTE PRESENTER:** Ronald Kessler, Ph.D., Project Director, Institute for Social Research

10:00 **KEYNOTE PRESENTER:** Mary Jane England, M.D., President, Washington Business Group on Health

10:30 **BREAK**
South Gallery

10:45 **TRACK SESSIONS**
See Track Team Assignments list for your room assignment.

Track goals and purpose are discussed by the Track Coordinator; the Track Facilitator summarizes processes and facilitates introductions.

11:30 **PRESENTATIONS/COMMENTS BY TRACK PARTICIPANTS**

The Track Facilitator coordinates presentation of materials and any discussion of issues.

12:00 PM **LUNCH ON YOUR OWN**

1:30 **TRACK SESSIONS CONTINUE**

Track Facilitator discusses processes, facilitates prioritization of questions and recommendations; recommendation development begins.

3:00 **BREAK**
South Gallery

3:30 **TRACK SESSIONS CONTINUE**

5:00 **ADJOURNMENT OF DAY ONE**

Tuesday, November 14:

8:00 AM **CONTINENTAL BREAKFAST**
South Gallery

8:30 **PLENARY SESSION: SERVICE NEEDS—SERVICE ISSUES**
Grand Ballroom H

Moderator: Bert Pepper, M.D.

Panel #1: CONSUMERS and FAMILIES
Barbara Huff, Federation of Families for Children's Mental Health
Joseph A. Rogers, Executive Director, National Mental Health Consumers Self-Help Clearinghouse
Johnnie Allem, CSAT National Advisory Council

Panel #2: STATE DIRECTORS
John S. Gustafson, National Association of State Alcohol and Drug Directors
Karen Schrock, Chief, Center for Substance Abuse Services, Michigan
Stephen W. Mayberg, Ph.D., National Association of State Mental Health Program Directors
Thomas M. Fritz, Ph.D., Director, Division of Alcoholism, Drug Abuse and Mental Health, Delaware

Panel #3: SYSTEMS INTEGRATION
Thomas Henderson, Director, Washington Office, National Center for State Courts
Nan Roman, Vice President, National Alliance to End Homelessness
Francis Foye-Adil, Program Director, Harbor House, Inc./Argus Community, Inc.

10:00 **BREAK**
South Gallery

10:15 **TRACK SESSIONS CONTINUE**
See Track Team Assignments list for your room assignment.

Track Facilitator reviews Day One accomplishments, identifies remaining issues and establishes goals.

12:00 PM **LUNCH ON YOUR OWN**

1:00 **TRACK SESSIONS CONTINUE**

Appendix B

Statements of the Plenary Presenters

Opening Remarks by Max Schneier, J.D. for the SAMHSA Conference on "Improving Services for Individuals with Co-Occurring Substance & Mental Health Disorders" November 13–14, 1995

On behalf of the SAMHSA National Advisory Council's Subcommittee on Services Integration, I welcome all invited guests and participating experts to this long overdue conference on "Improving Services for Individuals (of all ages), with Co-occurring Substance Abuse and Mental Health Disorders."

Colleagues, unlike most other conferences you and I may have attended on this or related subjects, all of us gathered here are charged with, and have the responsibility, *to develop recommendations* in each of the six tracks, to which you have been assigned because of your special expertise, that will successfully address and provide answers to the problems that obtain, and to develop strategies to ameliorate or overcome the impediments that hinder the successful resolution of these problems.

I know that, because of your "hands-on" experience, your recommendations will be cost-effective in both human and economic terms. Those recommendations—when approved by SAMHSA's National Advisory Council, and after consultation with Dr. Chavez and the Directors of SAMHSA'S three Centers—CSAT, CSAP and CMHS—will then be transmitted to HHS Secretary, Donna E. Shalala, as required by Section 102 of Public Law 102-321, enacted by the 102nd Congress on July 10, 1992.

That section states in part: "SAMHSA's National Advisory Council (appointed by the Secretary) *shall advise, consult with, and make recommendations to the Secretary and the Administrator* (of SAMHSA); concerning matters relating to the activities carried out by and through the Substance Abuse and Mental Health Services Administration and the policies respecting such activities." (That same mandate pertains to the National Advisory Councils appointed by the Secretary to each of SAMHSA's three centers—CSAT, CSAP and CMHS). That same section also gives the Advisory Councils the ability to "*appoint subcommittees and convene workshops and conferences.*"

So we are here legally gathered to carry on with our most important work which will have significant effect on the present and future well-being of millions of persons with co-occurring mental and addictive disorders.

Professor Kessler will soon apprise us of the actual numbers and breakdowns.

Yes, my fellow colleagues, this is the first time that we have real opportunity to make a difference. There will be no shelving or filing into oblivion of your collective

recommendations. They will be forward to Secretary Shalala with a suggestion for their immediate implementation—by HHS regulations wherever possible. It is my reasoned belief that many of the recommendations that will be forwarded can become operational via the regulatory process, and not require Congressional legislation.

I cannot foresee Congressional opposition because what we will recommend will lead to desirable cost-effective outcomes. And for those recommendations that may need legislative action, I also believe that the Secretary, the SAMHSA Administrator, and the three Center Directors, will be able to make a compelling case for such enabling legislation at future hearings conducted by the relevant Senate and House Committees because they also will have cost-effective underpinnings.

As many of you know, the problems and costs to the service delivery system that provides support to the co-morbid population at the State and local levels have led to repeated "turf" issues at those levels, which in turn have resulted in a harmful lack of cooperation between State and local Mental Health and Substance Abuse authorities and the programs they fund, in whole or in part. Integration of co-morbid services rarely exists.

Much of the onus for this unacceptable state of affairs can be placed on the lack of a Federal leadership role in past years, by ADAMHA and its three institutes, NIDA, NIAAA and the NIMH, and the domination and control of the existing minimal service components by the research fraternity in each of this institutes—more pronounced in the NIMH. Thankfully, Congress finally reacted to the long years of pleas and entreaties by services advocates to separate services from research—even though that separation was vigorously opposed by the Director and researchers of the NIMH, and the leadership of a national advocacy organization.

The progress that SAMHSA and its three Centers have made since they were created in 1992 is eloquent testimony for the need for such continued separation.

Hopefully, the recent conference of State MH, SA, and Medicaid Directors, and their declared promises to work together on an on-going basis, bodes well for the future. However, there is a desperate need for Federal leadership, programmatic information, and outcome data, which, unfortunately, was woefully lacking before the creation of SAMHSA and its three Centers. This conference will go a long way in providing the heretofore missing Federal leadership and the information and data necessary to help State and local Mental Health and Substance Abuse authorities, and local service providers, to implement cost-effective integrated services that will lower the length of hospital stays; significantly reduce the re-hospitalization rate, as well as the overuse of acute care and emergency room facilities; and make inroads on the daily total reliance on the community support services system by many consumers.

There are, indeed, better ways to tackle these problems. The state-of-the-art has moved much more rapidly than the implementation of the knowledge and experience we have gained, especially during the past decade.

When I think of all the years that have gone by without Congress having meaningfully addressed, and/or made provisions in legislation, for the vast co-morbid population, I have sought answers for that detrimental oversight. I can find but one answer, and that is that House and Senate Committees were never made aware of that huge problem—which was, and is, costing the nation untold billions of dollars in direct and indirect costs—by either ADAMHA or its three Institutes when testifying before the relevant Congressional Committees! I can find no evidence of any such past testimony that addressed and stressed the needs of this ever-growing population group. And if I have overlooked such testimony, then it certainly was not persuasive.

It is, therefore, to Dr. Chavez's credit, that in her recent testimony before Senator Kassebaum's Senate Committee on Labor and Human Resources that she included extensive remarks about co-occurring mental illness and substance abuse. Dr. Chavez stated to that committee on July 27, 1995, "The problems of persons with co-occurring mental illness and substance abuse are visible everywhere. These individuals are overrepresented among homeless persons and those involved in the criminal justice system." "SAMHSA will develop demonstrations to identify more effective ways to treat these conditions and to address the multiple needs of individuals with co-occurring disorders. Solutions will benefit all Americans through improvement in the quality of life and cost savings for the general community."

And that testimony, as well as the direct involvement of certain individuals, have already produced some tangible results, albeit not to the extent needed. Senators Kassebaum's and Kennedy's staff persons involved with such issues introduced language into the Demonstrations Grants section—albeit permissive language—that advised the States that they may list persons with co-occurring disorders as a "priority population." We should encourage State Substance Abuse authorities to propose Demonstration Grants to the Secretary of HHS—who must approve such requests—that will provide residential and rehabilitative programs for the co-morbid population, and for cross-training of Substance Abuse facilities' staffs. Both are unconscionably lacking, or are minimally addressed in most States of our nation. We should not forget that Substance Abuse Block Grant is five times greater than the Mental Health Block Grant. I am grateful that we finally have our "foot in the doorway." We must diligently attempt to open that doorway even wider during preparation of the fiscal 1997 Federal and State budgets.

I believe that both Ms. Baker of Senator Kassebaum's staff, and Ms. Thom of Senator Kennedy's staff are present. I would ask them to please rise so that this audience can acknowledge their much-needed efforts and contributions which they made towards inclusion of such specific language for the first time.

This conference is the culmination of more than 20 years of personal efforts to bring the plight and suffering of ten million Americans who have been dually diagnosed to the Congress' and the Nation's attention. Some of you have contributed your own

ongoing efforts toward that same goal. We must make the most of this exceptional opportunity to really "make a difference."

Thank you.

Max Schneier, J.D.
Chair
Services Integration Sub-Committee
SAMHSA National Advisory Council
6200 So. Falls Circle Drive, Apt. 413
Lauderhill, FL 33319
Tel. (305) 484-3129

May 13, 1996

Max Schneier, J.D., Co-Chair
Integrated Services Committee
6200 S. Falls Circle Drive
Lauderhill, FL 33319

Dear Mr. Schneier:

I am writing this letter to support the integration of mental health and substance abuse intervention in the treatment of persons with co-occurring mental and substance use disorders. My professional career spans over thirty-three years of working with persons with these disorders. Unfortunately, I have worked in programs which treated mental disorders only and when use of alcohol or other drugs surfaced, these clients were usually discharged, or later in the sixties referred to a substance abuse program. During the late sixties and seventies I observed the reverse process occurring with our substance abuse partners on Long Island New York. We moved to a parallel model of treatment in the eighties. Coordination was the "buzz" word. Yet most consumers were "buzzed" by the lack of coordination among programs. The mental health and substance abuse systems have developed their own ideas about treatment and persons with dual disorders are at high risk for being mislabeled, overlooked, rejected, discharged and generally misunderstood. This has not occurred out of any negative intention but is due to the limited training of staff in working with persons with co-occurring mental and substance use disorders.

An integrated model of treatment for this population is the preferred one. In this setting an individual receives clinical interventions for both disorders simultaneously by cross-trained staff. Our program, The Florida Center for Addictions and Dual Disorders has seen the value in this model. The advantages are very simple and direct: 1) it produces far better clinical results and prevents the shifting of the burden of treatment back and forth among providers where the consumer often gets lost or mistreated; 2) it is far more cost-effective: for example in 1992 the Florida Center had 78 employees and a 2.5 million budget to provide substance abuse services to 60 residents. Over half of these residents had a mental disorder which generally went untreated.

Today, the center offers integrated services at a cost of 1.6 million dollars with 37 full-time staff. Our clinical, functional, and quality of life outcomes are much improved over short and long term. We have a six to eight week waiting list. Our program is serving as a model for mental health and substance abuse providers. For example, North Florida Evaluation Treatment Center (NFETC) has established Hope Lodge on its campus in Gainesville utilizing the integrated model. It has found that residents in other units request to move to the Lodge.

In light of the above, I would strongly urge your committee to take a firm stand for integrated services over the present inadequate system of coordination. It has not worked and it cannot work due to the dichotomy in approaches to treatment held by mental health and addiction professionals. We must come together if we are to meet the clinical needs of the ten million Americans suffering with co-occurring mental and substance use disorders.

Sincerely,

Arthur J. Cox, Sr., DSW, LCSW
Program Director
Florida Center for Addictions and Dual Disorders
100 West College Drive
Avon Park, FL 33825

SAMHSA Improving Services: Co-Occurring Substance Abuse and Mental Health Disorders Meeting November 13–14, 1995

The Dual Diagnosis Dilemma

I was delighted to receive an invitation to speak at this critical conference and to have the opportunity to learn from the remarks of other presenters and participants. I was especially pleased that the subject area was to be "dual diagnosis." For a variety of reasons, the dual diagnosis client has occupied much of my professional thought for more years than I care to admit to.

When I play word association with the term dual diagnosis, the response that immediately comes to mind for me is that of "dilemma." The dual diagnosis client presents a dilemma on any number of levels. My dilemma when thinking about this presentation was what very small segments of this very complex and pervasive issue do I pick to talk about in the short time that is available.

Perhaps the first thing I'd like to touch on has to do with the estimates we get on the magnitude of the problem. Those estimates tend to obscure as much as they clarify. We have all heard estimates that suggest that the level of overlap between mental health conditions and substance abuse conditions runs between 35 and 45%. Reports coming out of institutional settings such as correctional facilities and inpatient psychiatric hospitals often contain figures indicating co-morbidity levels in the 60 to 80% range. my problem with these numbers is not that they are inaccurate. I suspect they are pretty close to being right on the money. The problem is that these rather global figures foster the impression that dual diagnosis is somehow just one more diagnostic category and that patients in that diagnostic category essentially share the same symptomatology. Of course, that isn't the case. The individuals classified as dually diagnosed make up an almost infinite number of sub-categories. To know that 40 or 60 or 80% of substance abuse or mental health clients are co-morbid tells us almost nothing about what we need to know to plan and provide effective treatment.

At the risk of seeming to preach to the choir, I would suggest that we do our professional fields and our clients a disservice when we speak of the dual diagnosis client or the dual diagnosis issue. To my mind, it would be much more meaningful to frame our discussions around such terms as the drug dependent schizophrenic, addicted clients with bipolar disorders, and borderline personality with chemical dependence. By using such expanded and more specific terminology, we are able to instantly convey a sense of the complexity involved in addressing both client and system needs.

For example, drug dependent schizophrenic suggests the need for staff that can prescribe and monitor neuroleptics, and which have skills in nonconfrontational forms of abstinence training and psychotherapeutics such as those offered by psycho-educational techniques. It suggests the need for intensive case management along with a strong sense

of chronicity. In the case of borderline personality with chemical dependency, the treatment implications brought to mind are abstinence through more traditional AOD treatment and psychotherapy which might be relatively confrontational.

Nearly all prevalence studies of co-morbidity provide us with the detailed information needed to speak knowledgeably about the level of co-morbidity associated with *specific* mental health and substance abuse diagnoses. To the extent possible, we need to fight our natural tendencies to collapse categories and speak in terms of general results. At the very least, we should begin speaking about the co-occurrence of substance abuse disorders in individuals with mental disorders characterized by psychotic, mood, anxiety, or personality features.

A useful byproduct of the consistent use of more specific terminology may be a greater acceptance of the need for longer-term, continuing care for specific types of co-morbid patients. Discussion of care for a drug dependent schizophrenic is much more likely to be seen as justifying the need for longer-term care than would be implicit in the use of the term dually diagnosed.

Why is it so important that we foster increased awareness of the need for long-term continuing care? I'd like to quote for you a note that I took during a presentation by Bert Pepper, who many of you here today know well. During his presentation, Dr. Pepper indicated that "The most common cause of psychiatric relapse today is the use of alcohol, marijuana, and cocaine" and "The most common cause of alcohol and other drug relapse today is untreated psychiatric conditions."

Both chemical dependency and many mental disorders are chronic, relapse prone conditions. It is absolutely unrealistic to think that short-term, discrete therapies will have self-sustaining, positive effects.

In an age in which the efficacy of both AOD and mental health services are under intense scrutiny, it is critical that we do everything in our power to retain clients in treatment for an acceptable period of time or we will see relapse rates jump. To those financing our treatment services, an increase in relapse rates will "prove" that they are right about the lack of effectiveness of our services. There is every reason to believe that any "proof" of treatment ineffectiveness will be used to justify decreased coverage. We are already seeing some evidence of this trend in managed care environments.

On the positive side, I can report that, at least among professional circles within the mental health and substance abuse fields, there is a broad based recognition of co-occurring mental health and substance abuse disorders and that both types of disorders can be considered primary. Ten years ago, this was not the case. At that time, I frequently heard mental health practitioners indicate that drug addiction and alcoholism were simply symptoms of a deeper underlying psychopathology. If the psychopathology were treated, the "need" to use alcohol and drugs would disappear. At the same time, many of AOD treaters felt that most of the mental disorders they saw in clients were the direct consequence of alcohol or drug use. Once the client was abstinent for a sufficient period

of time, his or her system would "clear" and the psychiatric symptoms would fall away. This has been a truly difficult learning process for both fields and one which holds great promise for our clients.

We have not, however, reached any consensus on how to best treat the co-morbid client. That is our next great challenge. Time doesn't permit a discussion of specific clinical practices, but I would like to spend a minute talking about the general treatment approaches available to us. As common sense would suggest, there are three basic approaches for treating both types of disorders in a single individual. The disorders can be addressed sequentially, in parallel, or in an integrated treatment scheme. By far, the most frequently used approaches are those that involve treating one disorder or the other on a parallel or sequential basis. In my experience, these efforts offer only limited potential for success. My rather limited attempts to keep up with both the research literature and less formal innovative programming strongly suggest that integrated services provide the greatest degree of gain for these clients. I suspect that most of our colleagues in both fields would agree—integrated services are probably the way to go.

If that is true, why are sequential and parallel efforts still the most common and why is little in the way of research support provided for integrated treatment development? The answers to these questions, at least from a governmental perspective, are quite simple: artificial administrative and fiscal boundaries. Within SAMHSA, for example, the Center for Substance Abuse Treatment cannot support demonstration projects that provide mental health services because that is the purview of the Center for Mental Health Services. On the research side, within the National Institutes of Health, the National Institute on Alcohol Abuse and Alcoholism's charter does not provide for the support of research that focuses as much on drug abuse and mental health as it does on alcoholism. The National Institute of Mental Health and the National Institute on Drug Abuse have corresponding constraints.

In the treatment field there are similar concerns. In the area of Medicaid we find, in most States, much broader coverage for mental health services than for substance abuse. Any of you who have attempted to "cost share" Medicaid reimbursement for clients with co-occurring mental health and substance abuse problems know what a daunting task that can be. At times, it can be dangerous from both a financial and a legal perspective.

Clearly, government is not now structured to benefit this population. I would urge you not to accept this. Our clients and their families should not have to navigate two separate, complex systems in search of appropriate services. Government policy makers, professional associations and grassroots advocacy groups all have an obligation to work for necessary change. Under appropriate pressure, government can change to accommodate the realities that dual diagnosis clients bring to us.

I am not arguing for merged substance abuse and mental health fields. The reasons for separate disciplines are many and legitimate, but do not need to be discussed here. What I am arguing for is a new level of flexibility for government agencies that will permit purposeful cooperative programming in areas of mutual interests, such as dual diagnosis.

What we need to understand as a society is that by not providing appropriate treatment to this population, we are already paying a heavy price in both human and financial terms. More and more frequently, the untreated dually diagnosed client winds up in the criminal justice system by default. That system is not only more expensive, but is ill equipped to provide even the most rudimentary forms of mental health or substance abuse services. The cost of this consequence in human terms cannot even be calculated.

If you think that my comment about the criminal justice system being used as the repository of last resort for these clients overstates the case, I would ask that you consider the following facts. In 1970, the United States had 500,000 State psychiatric beds and 300,000 individuals in prison or jail. In 1992, this country had only 100,000 State psychiatric beds, but more than 1,200,000 persons in jails and prisons. A 1990 study by Chiles and his colleagues of Washington State inmates found that 88% met criteria for a substantial emotional or psychiatric disorder. They also found that a full 92% met the criteria for a diagnosis of substance abuse or dependence. I'll allow you to draw your own conclusions.

Thank you for your attention and I look forward to your questions and comments.

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A Consumer Perspective

I have been diagnosed with both a mental illness and a substance abuse disorder; I am also the founder of a large, urban-based, consumer-run self-help organizing and service initiative called Project SHARE. I therefore find the issues addressed by this conference both personally and professionally compelling.

From my experience as a user of mental health services—even as recently as within the last four or five years—I would say that mental health professionals pay little attention to the way substance abuse exacerbates the symptoms of mental illness and keeps people in a destructive cycle of illness, repeated hospitalization, and homelessness. Our society has grown to accept a certain level of recreational drug use; unfortunately, while I doubt anyone can use these substances without some consequences, drug users who have mental illnesses can get into serious trouble. But only when I was hospitalized in a psychiatric hospital primarily run by recovering addicts did anyone even suggest that my use and misuse of alcohol and drugs might be contributing to my problems. As Dr. Bert Pepper has described extensively, even relatively small amounts of marijuana or other psychoactive street drugs can severely affect the stability of a person who is struggling with mental illness—manic depression in my case.

I have been there—homeless, on the street, out of my head on alcohol because I couldn't afford drugs, clueless as to how to get my act together; and I can tell you that we need to pay serious attention and expend serious resources on helping people recover from the dual problems of substance abuse and mental illness.

Through our self-help programs at Project SHARE, which is an arm of the Mental Health Association of Southeastern Pennsylvania, we have recognized this. And of course we believe that self-help groups and consumer-run programs can play an important role in the continuum of services.

For example, one of our programs—the Friends Connections (funded by the Philadelphia State Hospital)—offers peer support for people with mental illness and substance abuse problems. Based on the hypothesis that individuals with mental illness become involved with illicit drugs and alcohol out of a sense of loneliness, boredom and stigmatization, the Friends Connection seeks to counteract these negative factors by providing friendship, counseling, social support, and meaningful leisure-time activities. The program gives evidence of phenomenal success in keeping people out of the hospital. Its brochure states that clients "showed substantial decrease in hospitalizations. From a median of 316 days of hospitalization in the year prior to service, hospitalizations dropped to a median of three days a year."

The Friends Connection's director, Jeanie Whitecraft, attributes the success of the program to the fact that it is a program "without walls." The staff, who are all in recovery from substance abuse themselves, work one-to-one with clients in a friendship relationship as opposed to merely a counseling one.

Another of our programs, the Consumer Intensive Case Management Project, provides intensive case management services for people diagnosed with mental illness. Unlike many mental health programs, the project does not discriminate against people with dual diagnoses of mental illness and substance abuse. The project—the first consumer-staffed intensive case management service in the nation—originated as a Research Demonstration project, funded by the Community Support Program Section of SAMHSA's Center for Mental Health Services (CMHS). This research study, which compared intensive case management services offered by consumer and nonconsumer teams, found no significant difference in outcomes for clients.

Information about these and other models is disseminated by the National Mental Health Consumers' Self-Help Clearinghouse (of which I am the Executive Director), so that they may be replicated through the U.S. The mission of the Clearinghouse is to provide technical assistance and information-and-referral services to consumers interested in developing self-help programs related to mental health, and to promote consumer participation in planning, providing, and evaluating mental health and community support services.

The Clearinghouse is one of two national technical assistance centers funded by a grant from the Community Support Program Section of the CMHS. Over the years, CMHS has funded state-of-the-art, peer-run programs all over the United States, that help people with mental illness live successfully in the community. These low-cost services have an impressive record of helping people with mental illness decrease their dependence on social service agencies and stay out of the hospital (the most expensive form of treatment). Having proved effective, they have been replicated in numerous communities with state and local funding.

The model that all of these programs follow is the Community Support Program (CSP) model, designed nearly two decades ago. It involves a coalition of mental health consumers, family members, and professionals working to help adults with serious mental illnesses live successfully in the community.

CSP is based on creating opportunities for people rather than fostering a life of dependency and disability. CSP embraces the concept that people who have mental illnesses must be treated with dignity and respect; that these individuals have the same needs, aspirations, rights and responsibilities as other citizens; and that they must have access to the opportunities and supports everyone needs, as well as to a comprehensive array of mental health services.

CSP recognizes that traditional mental health services, such as inpatient and outpatient treatment and partial hospitalization, are not enough. Additional services such as housing, vocational training and employment, education, income maintenance, medical care, psychosocial rehabilitation (including consumer-run drop-in centers and clubhouse-model services), and transportation are also essential to help people live successfully in the community. CSP also understands the importance of peer-run services in a

comprehensive community support system. CSP recognizes the importance of helping people make a successful transition from inpatient treatment to living in the community.

We need more programs based on the CSP model, and we need more people in the mental health and substance abuse systems committed to bridging the gap.

We must continue to raise consciousness concerning how to do a better job of recognizing the problems and involving consumers in solving the problems. And we must do better at coordinating services between substance abuse and mental health, so that individuals do not fall through the cracks. As advocates, no longer can we accept the mental health system's refusal to provide services to someone with a substance abuse problem, and the other way around. Providers and policy makers on the local and State levels must be held accountable. Boundaries have to be broken down and individuals must be served based on their individual needs and not based on cookie-cutter programs.

Thank you for the opportunity to speak to you today.

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Systems Integration for Children and Adolescents

The needs of children and adolescents with alcohol, substance abuse, and mental health issues are many, complex, and persistent.

Their condition in some cases is chronic, subject to repeated hospitalizations, relapse, school drop-out, and often requires long-term treatment. Consequently, it is critical that a continuum of care exist within any agency dealing with our children.

A continuum of care provides for a wide range of services consistent with the needs of the children/adolescents, in an environment where coordination, cooperation, and collaboration exist between service providers, special services, juvenile justice, schools, mental health, and drug treatment programs.

Services should be organized and delivered through a system responsive to the local and State planning processes, and the Federal Government should function as the monitor.

We must first begin with identifying the child/adolescent problem early, be it, mental health, substance abuse, or basic literacy. We should provide a continuum of care that allows the parent access to services cafeteria style, at any time and at any point on the continuum, depending on the course of the disease.

The continuum is also a prevention model in the public health sense, meaning that it not only includes primary prevention services before age 5–15 onset, but also secondary intervention, treatment, and relapse prevention services.

Children/adolescents need an environment that they can feel safe in and that is drug free. If this environment is not the home, then they need experienced people providing low-cost community-based alternatives, including programs that address comorbid psychiatric disorders.

Children/adolescents need to learn honesty, obedience to the law, respect of self and others, motivation towards school and work. But in order for this to happen, they need to be mentally stable and drug free. This is not too much to ask for: Each human being deserves to be treated with love and respect and have their basic needs addressed. When children are brought up in a loving and nurturing environment they are able to meet, challenge, and overcome most obstacles. Most of all, children's parents must advocate for them.

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Improving Services for Homeless Persons with Co-Occurring Substance Abuse and Mental Health Disorders

Thank you for inviting me to be here with you today. I am Nan Roman, Vice President of the National Alliance to End Homelessness. The Alliance is a membership organization of some 2,800 nonprofit and public sector agencies which provide housing and services to homeless people. Founded in 1983, we do two things: we work to improve the capacity of our members to help homeless people through training, technical assistance, and information services; and we act as advocates at the Federal level to help homeless people.

I am not speaking to you today as an expert on mental illness or substance abuse illness—but certainly you have plenty of expertise on these issues gathered here, today. Rather I would like to speak to you as an advocate for homeless people. I want to speak to you about some of the difficulties they face. Secondly, I want to speak to you about the future and how we must plan for it.

On the issue of homeless people who are dually diagnosed, I have read the literature that preceded this conference and listened for the past day to the discussions. A few thoughts have emerged. First, I am perplexed by the linking of homeless people with people with a criminal justice history. Certainly there is some overlap, but the nature of their problems is quite different in terms of access to services, necessity of outreach, and, perhaps most starkly, their housing status. I frankly do not see the sense of linking the two in an effort at policy formulation.

Secondly, I want to stress that dual diagnosis is not only a cause of homelessness—it is also a result. Certainly I hear anecdotally that people with mental illness who did not necessarily have any substance problems become involved with substances on the streets. So not only will dealing better with dual diagnosis help prevent homelessness, dealing with homelessness will help prevent the deterioration of people with a single diagnosis into multiple diagnoses.

Third, there seems to be a significant number of homeless people who have an additional diagnosis—that of HIV/AIDS. This can also be both a cause or a result of homelessness. Given the complexities of dealing with dual diagnoses, imagine the difficulties if you add still another illness and stream of assistance to the mix.

Finally, and most importantly, the prime issue for homeless people that is left out of so much of this discussion is housing. Treating people with multiple diagnoses while they are living on the streets obviously presents its own special problems. The first of these is outreach. People with multiple diagnoses who live on the streets can be very difficult to reach. They have been failed by a multitude of systems, they are suspicious, they are fearful, and many of them have developed successful mechanisms of hiding from the world of institutions and systems. A patient process is required to engage them in

shelter—much less treatment. We have many homeless providers that have specialized in doing so. But we have few shelter systems that can accommodate the fragile people whom they bring in off the streets.

Things are about to change in the most significant way in our country in terms of how we deliver assistance to homeless people and those with multiple diagnoses. Devolution of responsibilities to States and localities through block granting; cuts in funding; removal of entitlement status; elimination of drug/alcohol abuse illness as a disability—all of these trends both in your own programs and in related programs such as housing will have a major impact on the population you are concerned about. We **cannot** assume that we can simply continue our current programs with refinements and reductions—tinkering around the edges. These changes will alter the landscape in which we work and we must take the appropriate steps, now, to address them.

Here are some suggestions:

- **Improve the mainstream programs.** Over the past few years SAMHSA has conducted various demonstration programs and much research showing us how to deal with people with dual diagnosis, including those who are homeless. These programs—such as ACCESS—have done excellent work. Now is the time to take the lessons learned from these programs and apply them to the mainstream programs. We ask that those of you who conducted these demos and research programs act aggressively to integrate what you have learned into all programs. We ask those of you in a leadership position to seriously look at these lessons and how you can make changes in the mainstream programs that will make them work for the most vulnerable populations. Remember, the mainstream programs have not worked for homeless people with multiple diagnosis—that is why we had to establish the McKinney programs to begin with.

- **Improve access to the mainstream programs.** Our organizations need the tools to help them get into the resource allocation process of the mainstream programs when they devolve to State/local government. As block grants are designed, we need to make sure that needs are properly identified (including the needs of people who are difficult and unpopular to serve); that spending addresses priority needs (in other words if multiply diagnosed homeless people are the biggest problem in a locality, resources should be applied to address this problem); that organizations (public and nonprofit sector) which assist multiply diagnosed homeless people and others are involved in planning how resources are to be allocated (sometimes called citizens participation) not just approving spending plans after the fact; and that outcomes are seriously evaluated. Many of these tools can be included in block grants through regulation.

- **Provide leadership to the States/localities.** We ask you to look carefully at how to communicate the lessons learned from demos and research to States and localities. There is no doubt that more of the responsibility for deciding how to spend funds will reside with State and local governments. They need your guidance and expertise in

deciding how to serve difficult and expensive to serve populations. They also need incentives to do so. We encourage you to look at setting aside funds for integration of services and to consider providing funding incentives for cities/States that do integration of assistance. In the current climate, demonstration money could better be used as an incentive to integration at the State/local level than in further expensive demonstrations that prove things we already know and cannot afford to implement in any case.

- **Coordination.** If you don't want people with dual diagnosis to become homeless or if you want to truly stabilize dually diagnosed homeless people, you have to deal with housing. At a recent Alliance Roundtable, Secretary Cisneros of HUD expressed that his primary concern on the homeless front at present is the issue of people with multiple diagnoses. He wants to work with you on this issue, and he is willing to bring resources to the table for housing. This is a terrific opportunity. We have seen over and over again that, although case management can accumulate the pieces of income, housing, and service assistance that a person needs, these pieces still may not fit together into a useful whole—they can be accumulated but not coordinated. This kind of coordination has to take place at the source—at the policy level.

- **Homeless assistance can be a model.** Again on the issue of coordination, I would urge you to look at the homeless programs as a model. Much of the discussion here today has been around integration of service assistance. At least for the population I'm concerned about, service integration is only a part of the puzzle—income and housing make up the rest. Homeless organizations around the country have found ways to successfully integrate these three elements using resources of every type imaginable. They are an excellent model of what can be done.

In closing, I fully expect that we are going to see a substantial increase in homelessness in the coming year, and even more so in the following year. Even if things were to turn out exactly as the current Congress says they hope and intend them to, many people will fall through the cracks in a transition. An increase in homelessness will mean an increase in homeless people with multiple diagnoses. Over the past few years, SAMHSA has done marvelous demonstration and research work on this population. Now is the time to implement the results of this research with a vengeance. We will no longer have the luxury of **examining** problems like this—we must **act.** You have the tools. We at the National Alliance to End Homelessness look forward to working with you to use them.

Nan Roman
Vice President
National Alliance to End Homelessness

Michigan's Plans for the Impact of Managed Medicaid on Individuals With Co-Occurring Disorders

In the summer of 1994 a new Medicaid mental health managed care system was proposed. Leaders representing the Michigan Department of Mental Health (DMH), Community Mental Health Services Centers (CMH's), the Michigan Department of Public Health/Center for Substance Abuse Services (MDPH/CSAS) and regional substance abuse coordinating agencies (CAB) began a series of meetings. They came together to study the needs of individuals with co-occurring substance abuse and mental health disorders within a managed care system for Medicaid-funded mental health services. They produced four collaborative planning documents by the end of 1994: a list of policy initiatives; an action plan; a definition of co-occurring disorders; and guidelines for local interagency agreements. Most importantly, key recommendations went beyond the Medicaid population and led to the formation of an interdepartmental steering committee by March of 1995. The most immediate result was that both DMH and MDPH/CSAS required that each CMH and CA develop a local interagency agreement with each other by October, 1995. Each interagency agreement includes a plan to coordinate and develop services for the population with co-occurring disorders for that particular locale. Each plan must address the following areas:

- Access, assessment, case management, and referral (e.g., emergency services, screening and assessment, discharge and referral issues, treatment coordination)
- Training and staff development
- Collaboration: local planning priorities, joint programming, planning meeting schedule

At the current time the interdepartmental steering committee continues to meet and has as its most immediate goals:

- To finalize a formal interdepartmental agreement ensuring continued collaboration between the mental health and substance abuse systems
- To provide review and oversight to all interagency agreements
- To develop a training committee to assess training needs and develop a Statewide staff development plan
- To provide technical support and ongoing joint planning to collaborative regional and local programs

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Recommendations to SAMHSA

1. SAMHSA needs to recognize that State authorities are moving into a new role of health care purchaser. SAMHSA can greatly assist States in being better purchasers of health care by ensuring that individuals with co-occurring disorders receive timely and appropriate care. Best practice models and standards of practice can be built into managed care contracts.

2. SAMHSA needs to help States define indicators to measure utilization of health resources in order to evaluate cost offsets as a result of dual disordered individuals receiving timely and appropriate care.

3. SAMHSA needs to become a player and expert in the financing of behavioral health care. SAMHSA must protect funding streams to ensure ongoing service delivery. SAMHSA must partner with HCFA and be seen as a valuable agency.

4. SAMHSA needs to rapidly develop more sophisticated and comprehensive placement criteria that includes the dual disordered.

5. SAMHSA needs to work with the APA's State/University Collaboration project to address curriculum and skill acquisition of graduates. SAMHSA also needs to help get the collaboration project into States where there is no medical school.

6. SAMHSA needs to develop minimum practice standards addressing dual disorders which could serve as basic requirements for accreditation.

7. SAMHSA needs to provide input into accrediting bodies (i.e., JCAHO, NCQA), suggesting recommended standards for dual disorders.

8. SAMHSA needs to ensure that dual disorders are addressed in the Healthy People 2000 report revisions. In addition, SAMHSA needs to address this matter with States in block grant or performance partnership grant processes.

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Appendix E

Responses to This Report From SAMHSA, CSAT, CSAT's National Advisory Council, and the National Institutes of Health, and an Update From the Author, Dr. Bert Pepper

MAR 1998

SAMHSA RESPONSE TO THE SAMHSA NATIONAL ADVISORY COUNCIL'S REPORT ON IMPROVING SERVICES FOR CO-OCCURRING SA/MH DISORDERS

The Substance Abuse and Mental Health Services Administration (SAMHSA) is pleased to have received the enclosed report of the SAMHSA National Advisory Council, *"Action for Mental Health and Substance-Related Disorders: Improving Services for Individuals at Risk of, or with Co-occurring Substance-Related and Mental Health Disorders: A Conference Report and National Strategy."*

The SAMHSA Advisory Council's report addresses a critical issue confronting the substance abuse and mental health services field and draws on the work of the many participants convened at SAMHSA's November 1995 national conference, "Improving Services: Co-occurring Substance Abuse and Mental Health Disorders." The document's goals, objectives and strategies are based on both conference work and input solicited from a panel of Federal and non-Federal reviewers. Contributors are identified in an appendix to the document.

SAMHSA's Conference was supported as a forum to facilitate a national dialogue on important aspects of improving services for the millions of Americans identified as having more than one separate, diagnosable, and simultaneous substance abuse and mental health disorder in their lifetime. It is important to note that the purpose of the conference was a convening of recognized experts where issues could be confronted in a face-to-face brainstorming session which would result in a systematic response to the myriad of issues underlying the provision of services to dually diagnosed people. It is also important to clearly state that SAMHSA does not endorse any of the specific recommendations made in the Council report but has taken the recommendations of the conference participants under advisement as part of the basis for future agency-wide programmatic and policy decisions.

There is no doubt that the report and its recommended strategy identify a number of highly controversial issues. Some elements of the report, including the ECA and NCS estimates of the prevalence of co-occurring substance abuse and mental health disorders, continue to be hotly debated--and the exchange will likely persist. The strategic recommendations address both clinical and non-clinical issues. Some recommendations are founded in empirical research; others are made on the basis of years of practical clinical experience with the dually diagnosed population. Some have remedies in a variety of mechanisms, others continue to perplex the most informed of experts.

As indicated in the report, the recommendations are the products of the track discussion participants, with the proposed National Strategy derived from those recommendations. The development process included no formal votes or consensus building formats. While the identified goals are admirable, some of the recommended strategies for achieving them are not equally supported by the mental health and substance abuse fields. Some of the recommended strategies are not feasible given the current and anticipated fiscal and political environments at all levels in the public sector. In some cases, the research base for recommending change in practice is lacking; in others, readiness, resources, or reluctance to change thwarts immediate action, even when there is agreement on a recommended approach.

In this paper, SAMHSA will respond to two of the most important issues raised in the report, as follows:

Merging or Blending Substance Abuse and Mental Health Block Grant Funds

One concept implicit in the report that has received intense reaction from both intra-agency sources and the field is that of blending Substance Abuse Prevention and Treatment (SAPT) Block Grant and Community Mental Health Services (CMHS) Block Grant funds or merging the programs to facilitate better access to dual diagnosis services. The track discussions and resulting recommendations suggest that the real issue is the exploration and implementation of more flexible mechanisms to meet the services needs of clients. This recommendation was made in recognition that people with substance abuse problems often have underlying mental health issues; that people with co-occurring SA/MH disorders need both substance abuse and mental health services; that untreated mental health problems can negatively influence the recovery potential for substance abuse clients; and that separate funding streams and restrictions on the use of funds are regarded by some as limiting access to necessary services for the dually diagnosed.

In response, neither SAMHSA nor any other component of the Administration has proposed merging the SAPT and CMHS Block Grants. Legislative action would be necessary to combine these programs and Congressional intent in creating and maintaining separate Federal funding streams for substance abuse and for mental health services is abundantly clear. Further, the Administration's 1997 SAMHSA Reauthorization Proposal submitted to Congress last year maintained separate authorities for both programs as Performance Partnership Block Grants. Consistent with this, the FY 1998 budget approved by Congress and the President's budget request for FY 1999 maintains the Performance Partnership Block Grants as two discrete efforts.

This position is also consistent with the Administration's new Federalism concepts. We believe that coordination of Federal substance abuse and mental health funding as well as funds from the criminal justice system, health care and welfare programs, etc. is better accomplished at the State level, where local needs are better known. Coordination at this level also allows States and local entities to exercise the flexibility that is necessary to ensure the cross-system resourcing and collaboration needed by service providers working in separate public systems to address the concerns of multi-need clients.

We also need to dispel the perception that the substance abuse field, through its SAPT Block Grant, can better afford to pay for dual diagnosis services than can the mental health field. In reality, the SAPT Block Grant provides a much greater proportion of the public funds available for substance abuse prevention and treatment services than the CMHS Block Grant provides for the support of mental health services. Rather than looking to assign the responsibility for funding dual diagnosis services to one field or the other, we must continue our efforts to develop a variety of financing mechanisms and combinations of funding streams for the services needed by clients in both fields so that we can achieve better outcomes for them.

Integrated vs. Coordinated Services

The Council report defines integrated treatment as "...simultaneous treatment of all disorders by a appropriately dually-trained clinician, or a unified treatment team whose members are competent to treat both the substance-related and the mental health disorders...ideally work(ing) for one agency." Some conference participants have refined that definition to mean "simultaneous services delivered by a dually trained clinician or team of specialty providers in a single setting, under the supervision of a psychiatrist." "Coordinated" treatment is described as a model where two agencies work with the client at the same time, each treating one disorder in a parallel or sequential fashion.

"Patients" or "clients" are understood by some to be people with two separate, yet simultaneous, diagnosable disorders and by others to be those exhibiting behavioral symptoms that mimic mental disorders but which dissipate or disappear with effective treatment of the primary problem. While the focus of the conference and report is on people diagnosed (using DSM-IV criteria) with two or more independent but simultaneous substance abuse and mental health disorders, definitional issues and perceptions have blurred the conference discussions and the Council's report and how they are being interpreted by the field. This makes it apparent that the field must move toward a better understanding of what we are talking about before we can make significant progress toward answering the best practice(s) and organization and delivery of care questions.

The Council report is decidedly in favor of services integration and this has generated a significant reaction, both pro and con, from the field. Whether a dually diagnosed person should receive treatment for both his substance abuse disorder(s) and mental illness(es) at the same time is a fundamental treatment issue. The issue is compounded by the lack of a clear, commonly understood and uniformly accepted definition of the term "integrated services" coupled with the lack of a firm research base supporting "integrated services" as the only or even the most effective treatment approach for all people with co-occurring SA/MH disorders. To some, integrated services is tantamount to integrated funding. To others, integrated services means case management or treatment delivered by multi disciplinary teams comprised of multiple cross-trained speciality providers. Conversely, these very same models are considered "coordinated services" by some. Also, while many professionals in both the mental health and substance abuse fields value the concepts of comprehensive services and one-stop-shopping, particularly for the severely and chronically ill, this is more an endorsement of an "integrated perspective" than it is a recommendation for treating all patients, regardless of their unique problems, in the same program models.

The jury is still out on the issue of what works best for this heterogeneous population. A recent review of 36 research studies on the effectiveness of integrated treatment[1] reported disappointing results associated with intensive integrated treatments in controlled settings and with adding dual disorders groups to traditional services. On the other hand, it reported encouraging evidence from a limited number of studies where comprehensive, integrated, outpatient treatment

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[1]Drake, R.E., Mercer-McFadden, C., Mueser, K.T., McHugo, G. J., and Bond, G.R. A Review of Integrated Mental Health and Substance Abuse Treatment for Patients with Dual Disorders. Schizophrenia Bulletin. In press.

programs were achieving success in terms of engaging dually diagnosed patients in services and helping them to reduce substance abuse and attain remission. This comprehensive review concludes, as do many other studies, that "given the magnitude and severity of the problem of dual disorders, more controlled research on integrated treatment is needed."

The range of "integrative solutions" is wide. SAMHSA acknowledges the many research studies and the emerging experiential data suggesting that integrated services are superior--for certain clients. We also acknowledge the studies suggesting that substance-induced symptomatology can mimic mental disorders and point out, for example, the need to distinguish between independent disorders, induced disorders, and those that are psychiatric conditions that appear to have developed independently but that improve with appropriate substance abuse treatment. In addition, we acknowledge that some experts legitimately believe that coordinated services can meet client needs as well as studies that show successful outcomes for non-integrative treatment approaches (e.g., where depression and depressive symptoms among treated opiate addicts remitted without specific mental health treatment[2] or where mood and anxiety disorders occurring among alcoholics dissipate over a period of four to six weeks of abstinence[3]).

As a field, we have made considerable progress in identifying the essential components of/ integrated treatment. As integrated treatment strategies become more commonplace, we will need to assess and add those experiences to the knowledge base on specific integrative strategies considered most successful for certain subsets of the dually diagnosed population. While new information is emerging at a rapid pace, more information is needed on the effectiveness, organization, and costs of services before a single, one-size-fits-all approach can be recommended or promulgated as a wholesale change to the nation's health service system. SAMHSA plans to work with its Centers, their Advisory Councils, national organizations, and the National Institutes of Health (NIH) to further assess the empirical basis for policy and programmatic guidance before issuing recommendations for revisions in practice or service systems.

SAMHSA Programs and Activities

While much time has elapsed since SAMHSA's November 1995 conference, the agency is taking deliberate steps to build services systems that are responsive to the needs of people with or at risk of co-occurring SA/MH disorders. Every SAMHSA component supports activities that address co-occurring disorders and we have begun new efforts every year since FY 1993. These activities range from brief technical assistance workshops for States to major KDA programs. In FY 1997 alone, SAMHSA spent $9.2 million for activities specifically targeting some aspect of service provision for co-occurring disorders. Over the past several years we have supported:

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[2]Rounsaville, B.J., Weissman, M.M., Crits-Christoph, K., Wilber, C., and Kleber, H. Diagnosis and symptoms of depression in opiate addicts; course and relationship to treatment outcome, Archives of General Psychiatry 39:151-156, 1982

[3]Brown, S.A. and Schuckit, M.A. (1988) and Schuckit, M.A., Irwin, M. And Brown S. (1990) as cited in Schuckit, M.A., Tipp, J.E., Bucholz, K.K., Nurnberger, J. I., Hesselbrock, V., Crowe, R.R., and Kramer, J. The Lifetime Rates of Three Major Mood Disorders and Four Major Anxiety Disorders in Alcoholics and Controls. p 23. 1997. In press.

- SAMHSA's 1995 Conference on Improving Services for Co-Occurring Disorders;

- direct technical assistance to States and training institutes for providers on assessment and treatment of dually-diagnosed adolescents, and other methods to strengthen the treatment service delivery systems for dually diagnosed clients;

- a joint CSAT/CMHS project with the National Association of State Alcohol and Drug Abuse Directors and the National Association of State Mental Health Program Directors to further clarify definitions, determine promising practices, and identify collaborative mechanisms and training methods to serve dually-diagnosed populations;

- publications and policy documents such as CSAT's Treatment Improvement Protocol on *Assessment and Treatment of Patients with Co-existing Mental Illness and Alcohol and Other Drug Abuse* that provides information on the definition of dual-diagnosis, descriptions of the mental health and addiction treatment system, chronicles basic mental health disorders, and presents substance abuse treatment and pharmacologic management and CMHS's *White Paper on Co-occurring Disorders Among Children and Adolescents* that describes the growing phenomena of co-occurring disorders among children and adolescents;

- projects such as CMHS's ongoing Mental Health/Managed Care Standards, Competencies and Guidelines for Co-occurring Disorders project which is developing training and technical assistance materials to ensure that current and future mental health providers are competent to provide quality, cost-effective services for persons with co-occurring mental health and substance abuse disorders;

- a joint CSAT/CMHS project at The National GAINS Center for People with Co-Occurring Disorders in the Justice System which provides technical assistance, information collection, and dissemination of effective mental health and substance abuse services for people with co-occurring disorders involved with the justice system, with special attention to the needs of women and adolescents; and

- knowledge development programs such as the joint CMHS/CSAT Collaborative Demonstration Program on Homeless Individuals which is documenting and evaluating treatment interventions for individuals with serious mental illnesses and/or substance use disorders who are formerly homeless or at-risk for homelessness, and who are engaged with the mental health and/or substance abuse treatment systems and the Criminal Justice Diversion Interventions for Individuals with Co-Occurring Mental Illnesses and Substance Abuse Disorders Program which is analyzing the effectiveness of pre- and post-booking models of criminal justice diversion in improving selected outcomes for individuals with co-occurring SA/MH disorders.

SAMHSA also supports other activities that do not specifically target this problem but that contribute to the overall goal of improving substance abuse and mental health services, including those that reach people with dual disorders. Examples of such activities include projects like the following:

- Surveys, such as the ongoing National Household Survey on Drug Abuse or the 1997 Mental Health Client/Patient Sample Survey which respectively collect information about alcohol and illicit drug use and about clients treated in specialty mental health organizations for mental illness and substance abuse issues, or who were referred/transferred to another facility; and

- The CMHS Projects for Assistance in Transition from Homelessness (PATH) formula grant program that provides funds to States for service delivery to mentally ill homeless individuals who may also have a substance abuse problem.

Many of these programs will continue in the future; new ones are on the drawing board and will be made public as they are further defined.

Conclusion

Our vision of the ideal system, as good as it is, must be based in research and tempered by the realities of fiscal, staff, and administrative influences that are often beyond our control. Some of the Council report's recommendations are clearly not feasible in today's environment; others can be easily implemented. All components of the field must work together to develop common definitions, principles, and goals for improved services. Some of the Council report recommendations may be within SAMHSA's purview, but require authorizing legislation before they could be undertaken. Care must be taken to ensure that recommendations are taken to the appropriate level of government and individuals contemplating action stimulated by the Council report should do a "reality check" on all the recommendations to ensure that those Federal, State or local entities having an overlapping role share in the responsibility for this patient population.

We remain challenged by the need to find ways to enhance existing resources and use discrete funding streams to provide appropriate services at the most appropriate point of delivery. At the same time, we remain committed to advancing the quality and effectiveness of prevention and treatment services for each discrete, but related, disorder. More information is needed before any wholesale systemic changes are made, and SAMHSA is prepared to nurture the partnerships and invest the resources needed to gain this information.

As SAMHSA moves forward, we will consider all methods of developing and sharing knowledge in order to improve outcomes for dually diagnosed clients. We are confident that the November 1995 conference and its resulting report has value for consideration by the mental health and substance abuse fields. By highlighting the issues, illuminating the controversies, and emphasizing known solutions, the enclosed report will serve as a catalyst for continuing attention and future action to improve services for co-occurring disorders in the substance abuse and mental health fields. As always, SAMHSA will seek out and welcome the involvement of both the substance abuse and mental health fields.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Substance Abuse and Mental
Health Services Administration
Rockville MD 20857

MAR 23 1998

TO: Acting Associate Administrator for Policy and Program Coordination

FROM: Acting Director, CSAT

SUBJECT: Comments on SAMHSA National Advisory Council Report on Co-Occurring Substance Abuse and Mental Health Disorders, for release with the report

Thank you for the opportunity to submit comments on the report from the SAMHSA National Advisory Council on co-occurring substance abuse and mental health disorders, and for extending that opportunity to CSAT's National Advisory Council. The complex needs of the many persons suffering from a combination of these two disorders indicate a need for a close and careful examination of any proposal for widespread changes. In today's environment of health care reform, the Federal government must be especially vigilant in protecting treatment services to the nation's most vulnerable populations. It is for this primary reason that CSAT cannot support the strategy proposed by SAMHSA's National Advisory Council. Clarification follows:

Although CSAT has always supported accessible and convenient comprehensive services, CSAT does not support the blending of block grant funds for substance abuse with those of mental health. Legislative action would be necessary to combine these programs, and the Administration's SAMHSA Reauthorization proposal submitted to Congress in 1997 maintains separate authorities for both programs as Performance Partnership Block Grants.

There are other concerns with a strategy that suggests blending block grant funding streams and imposing cross-training requirements on States and providers as the best way to improve

services. Controversy continues to surround the question of what constitutes "best practices" in treatment. While some studies support concurrent treatment, CSAT endorses treatment that begins with an assessment designed to identify the primary disorder, which would then indicate the appropriate sequence for treatment. Symptoms of mental illness are frequently removed or significantly reduced as a result of substance abuse treatment when substance abuse is the primary disorder. In such cases, substance abuse treatment is likely to obviate the need for costly mental health treatment.

Further, many experts and authoritative sources, including many who attended the November, 1995 conference, **Improving Services: Co-Occurring Substance Abuse and Mental Health Disorders**, have expressed their opposition to statements in the conference report relevant to concurrent treatment and blended funding, and have made the following points:

- 27.8 million Americans need treatment for alcohol and substance abuse, (*National Household Survey on Drug Abuse*, 1997), and ONDCP estimates less than 3 million are admitted annually, leaving a balance of 24.8 million. Of this number, approximately 10 million, according to the *National Co-Morbidity Survey* have a co-occurring substance abuse and mental health disorder. This informal analysis shows that approximately 14.8 million Americans have a substance abuse disorder for which they need treatment, but for which none is available at this time.

- More clinical and epidemiologic information regarding the dually-diagnosed is needed: the *National Co-Morbidity Survey* lacks critically important data on which diagnosis is primary versus secondary. An evaluation of the literature regarding the relationship between lifelong DSM-III-R anxiety disorders and alcohol dependence, supported by the National Institute on Alcohol Abuse and Alcoholism concluded, "[T]he high rates of comorbidity in some studies likely reflect a mixture of true anxiety disorders among alcoholics at a rate equal to or slightly higher than that for the general population, along with temporary, but at times severe, substance-induced anxiety syndromes." (**"Alcohol Dependence and Anxiety Disorders", American Journal of Psychiatry**, 12/94)

- A quality management study conducted by PacifiCare among its network of 7,000 behavioral health practitioners, and focusing on 702 co-occurring patients, concluded that "providers should treat a client's addiction before they begin to address mental health issues" (**Mental Health Weekly**, Vol 7,4/14/97).

- Alcohol and substance abuse can produce, mimic or worsen any psychiatric symptom or syndrome, and acute and chronic use of stimulants as well as depressants can produce pathological personality changes (Kofoed, L. ***"Assessment of Comorbid Psychiatric Illness"***, **Dual Diagnosis of Major Mental Illness and Substance Abuse Disorder**).

- Other studies have shown "..a period of abstinence or of being `drug free' is required to evaluate the effects from use of drugs and alcohol before definitive psychiatric diagnoses can be made in addition to the addictive disorder. Recommendations range from waiting a few days to years, depending on the syndromes or diagnoses, before making otherpsychiatric diagnoses and instituting treatments." (**Psychiatric Annals**, Vol 24.8, 8/94).

- The total national funding for substance abuse treatment in the States (FY '93) was approximately $3.7 billion, while the total funding for mental health services in the States was $14.4 billion plus nearly $6 billion more in Medicaid disproportionate share funds. Funding for mental health services, at $20 billion, far exceeds the total of $3.7 billion for substance abuse treatment (NASADAD).

- Of the total $23.7 billion available for substance abuse and for mental health services, funds for substance abuse represented 14.5% of the available funding resources, while those for mental health were at 85.5% (NASADAD).

- Substance Abuse Prevention and Treatment (SAPT) Block Grant funds provide nearly 40% of treatment expenditures reported by the States, support a large percentage of services nationally, and represent the majority of treatment funding in 21 States (CSAT, 1997).

- Many States are offering or implementing mental health benefits to the publicly-insured, but fewer States offer a substance abuse service array as a part of the State health benefit package (CSAT National Advisory Council).

In addition to these points, it is critical to consider the existing services delivery environment. A single approach cannot address the complexity of mandates, responsibilities, goals, needs, and interests that exist among Federal and State stakeholders. While there are many collaborative activities on behalf of dually diagnosed patients, little is actually known about what is being done, how it is happening, how cases are managed, and with what results. CSAT has been compiling and continues to gather information that will provide a clearer picture of how the States and their providers are responding to the problem of co-occurring substance abuse and mental health disorders.

Camille T. Barry Ph.D., R.N.

January 12, 1998

Nelba Chavez, Ph.D., Administrator
Substance Abuse and Mental Health
Services Administration
U.S. Public Health Services
5600 Fisher Lane
Rockville, MD 20857

RE: Report from SAMHSA National Advisory Council:
Improving Services for Individuals at Risk of, or with, Co-Occurring Substance-Related and Mental Health Disorders

Dear Dr. Chavez:

I am responding to your request for comments on the above-noted document in my capacity as a member of CSAT's National Advisory Council. Since 1994, I have served as the liaison between CSAT's National Advisory Council and the SAMHSA Council's Co-Occurring Disorders Committee. Further, I was a participant in the November, 1995 conference on which this document is reportedly based. On behalf of CSAT's National Advisory Council, I would like to thank and commend you for inviting comments to be included in this report. Council members have many concerns about the report's developmental process and content, and believes such concerns are appropriately expressed in a public forum.

1. The report attributes its contents to the deliberations of the 140 participants of the November, 1995 conference (Improving Services: Co-Occurring Substance Abuse and Mental Health Disorders), and one of the key recommendations pertaining to financing and managed care encourages "blending of split sources of private and public funds" such as the substance abuse and mental health block grant funds. However, CSAT's National Advisory Council does not support this recommendation.

   Further, as a conference-participant, I had been assigned to the work group focusing on financing issues and, as far as I am aware, this was not a recommendation raised or voted upon at the concluding sessions of the conference, and participants were not, as had been promised by SAMHSA, sent draft copies of the proceedings for their review and approval. As a conference-participant, I am concerned that my name, particularly in view of my position on CSAT's National Advisory Council, would be included as a "supporter of the national strategy" contained in the report.

2. In the development of this report, the role of SAMHSA's Council in relation to the advisory councils mandated for each of the Centers is unclear. This relationship is further clouded by the SAMHSA Council's endorsement of policy recommendations reportedly developed by the 140 conference participants. Members of CSAT's National Advisory Council were not included in the discussion, nor in any subsequent deliberations by the conference coordinators or the report author. CSAT Council members represent the large constituency of consumers and practitioners who would be most affected by the policy changes this report recommends. As you know, the CSAT National Advisory Council has had a long-standing resolution opposing the blending of split funding streams, which is in direct opposition to the recommendations endorsed by SAMHSA's Council. For this reason, CSAT Council members are understandably concerned that, despite repeated requests to be involved and informed, they were not consulted.

3. CSAT's National Advisory Council opposes any merger of the Federal block grants for substance abuse treatment and for mental health services. Shortly after its inception, CSAT's Council adopted a resolution opposing such a merger, and in 1997 that resolution was expanded and clarified. The reasons for opposition are many. Blending Federal funding streams is likely to:

   - Reduce access to appropriate care for dually diagnosed individuals who have a primary diagnosis of a substance abuse disorder

   - Erode that quality of specialized substance abuse treatment; mental health providers would, defacto, become the providers of first resort for persons having a primary diagnosis of a substance abuse disorder

   - Decrease the availability of substance abuse treatment; many States are implementing mental health benefits to publicly-insured, but few offer substance abuse services as part of a State health benefit package.

   - Limit access to substance services for especially vulnerable populations, like women, with highly specific needs; those most in need of specialized, intensive or extensive substance abuse services will have limited access to care or will not have the option of remaining in treatment long enough to derive clinical benefit.

   - Undermine the advances made in the effectiveness of substance abuse treatment, and the enhanced improvements to the national system of care.

4. Separate Federal funding for substance abuse and mental health services is supported by the history leading to the separation of those funds, which occurred in 1992. Prior to that time, the White House, Senate and House of Representatives asserted that block grant funds earmarked for substance abuse services were being used to provide mental health care to individuals who suffered from severe or chronic mental illness. Another concern was that Federal funds were not being administered in the most clinically efficacious manner, and not being utilized to serve the most vulnerable populations. The result was the separation of block grants by Congress, which carried numerous service requirements and population set-asides applicable to the substance abuse block grant. Under the existing system of separate block grants, Congress gave Governors the flexibility to integrate Federal funding to ensure the needs of the dually-diagnosed were met.

5. We need to do more to enhance the availability of effective care for these individuals, but before radical proposals for shifts in Federal funding are advanced, more data are needed. Data reported by the National Co-Morbidity Survey (NCS) omit critical information regarding the needs of and services to these patients, including:

   - Clinical or epidemiologic characteristics
   - Primary versus secondary diagnosis
   - Diagnoses having an explanatory value for type of treatment
   - States or regions suffering from highest-incidence rates
   - States' commitment to provide services; the availability and quality of care

In conclusion, the national substance abuse treatment sector now operates under demands and restrictions imposed by a variety of Federal and State downsizing, and reinventing or reforming health care. The resources required to meet these challenges cannot be derived from non-Federal sources. In the past and in the foreseeable future, the commitment by the Federal government to specific funding for substance abuse services is best-equipped to stave off the potentially epidemic re-emergence of the tragic consequences of substance abuse.

Respectfully Submitted,

Sushma D. Taylor, Ph.D., Member
Center for Substance Abuse Treatment
National Advisory Council

CC: Marjorie Cashion, Center for Substance Abuse Treatment

DEPARTMENT OF HEALTH & HUMAN SERVICES

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January 6, 1998

To: Mary Knipmeyer, Ph.D.
Acting Associate Administrator for Policy Coordination, SAMHSA

From: Associate Director for Science Policy, NIH

Subject: Improving Services for Individuals at Risk of, or with, Co-occurring Substance-Related and Mental Health Disorders: A Conference Report and National Strategy

We appreciate the opportunity to review the SAMHSA National Advisory Council conference report and strategy recommendations document entitled, "Action for Mental Health and Substance-Related Disorders: Improving Services for Individuals at Risk of, or with Co-occurring Substance-Related and Mental Health Disorders: A Conference Report and a National Strategy."

The Report contains very broad, ambitious goals and strategies designed to improve services to individuals with co-occurring mental health and substance abuse disorders. While NIH agrees that this is an important national issue, NIH cannot endorse the national strategy presented in the report. After reviewing the Strategy, NIH has many concerns and questions which are summarized below.

The Strategy currently fails to distinguish between the roles of research agencies and service-oriented agencies. While NIH appreciates SAMHSA's ambitious offer to coordinate all co-morbidity efforts, we believe that leadership for research efforts belongs squarely with the NIH and that leadership responsibility for services resides with SAMHSA.

There are several recommendations that do not reference all relevant agencies and, in some identify inappropriate agencies to implement these recommendations. For example, the report calls for "Comorbidity surveys of the juvenile justice and the adult criminal justice populations should be conducted. SAMHSA and the Department of Justice should collaborate on these projects." Several institutes including NIDA, NIAID, NICHD, and other agencies such as HRSA should also be included. The report also states that "Administrators and researchers from NIMH, NIDA, NIAAA, and SAMHSA should establish a joint research agenda on effective prevention, treatment, and services research on co-occurring disorders." While, the majority of NIH funded research is investigator initiated, NIMH, NIDA, and NIAAA each currently collaborate and seek input from external experts, including from the relevant SAMHSA centers, in developing their services research agendas. The Strategy also calls for SAMHSA to " provide direction in the

standardized collection of data about access, treatment, relapse, and other outcome measures." Research institutes such as NIMH, NIDA, and NIAAA would also provide valuable direction in this area and have many years of experience in this regard.

In this regard, the document needs considerable scientific review. For example, the Executive Summary states:"The most common cause of psychiatric relapse today is the use of alcohol, marijuana, and cocaine." and "The most common cause of relapse to substance use/abuse today is untreated psychiatric disorder." Neither of these statements are known on the basis of empirical evidence to be true and appear to be based on clinical judgments, since no empirical evidence is cited in the report to document these findings. Since the basis of most of the recommendations depend on these premises, the overall strategy proposed must be considered seriously compromised.

The report also does not adequately acknowledge past and ongoing research on co-occurring disorders. In order to develop a strategy to close gaps in knowledge and meet unfulfilled needs, a more thorough effort must be undertaken to first determine what is already known and identify current strategies and activities. For example, NIH and HRSA have a long history of supporting co-morbidity research and have a considerable portfolio in this area. A component of the proposed strategy calls for an evaluation of the clinical effectiveness of co-occurring treatment programs and the recognition of the principle of treatment evolution. NIDA and HRSA are already conducting research in these areas. Further, recommendations from the Child and Adolescent Track (p. 59) regarding the NIMH UNOCCAP survey states that NIH should "...encourage SAMHSA participation and that Juvenile Justice children should be included in the study. It should be noted that CMHS is a collaborating agency and Juvenile Justice children are included. Another example of ongoing research on co-occurring disorders is the joint NIDA and NIMH Program Announcement: Research on Comorbid Mental Health and Drug Abuse Disorders (PA-95-055).

In another case, objective I-C of the report recommends that an ongoing data-gathering system be established and maintained, and that collected data should provide information on the costs, effectiveness, and outcomes of prevention and treatment services. The report further recommends creating an entity to assist in this effort. It is incorrect that simply collecting data will inform us about: 1) the costs, 2) the effectiveness, and 3) the outcomes of prevention and treatment services. There must be clear conceptualization of who is getting what services under what circumstances in order to even begin to answer the questions of costs, effectiveness and outcome. This requires very careful conceptualization of who (with what disorder, personal and family characteristics, in what system or non-system of care) is getting what services/prevention (conceptualized, manualized, fidelity of implementation), with what outcome assessments (when and by whom).

Most importantly, the report fails to present clear conceptualizations of differing ways of integrating treatment programs and services; the need for manualizing and specifying what these ways of integration are; the need for assessing the fidelity of their implementation; and lastly, assessing their outcomes. Only when all of these steps have been accomplished, should cost or cost-effectiveness studies be undertaken. This report also fails to acknowledge the state of

knowledge and research in this area, or the difficulties of doing the research. Instead, it calls for collecting "data" which will provide limited, if any, information relevant to a very complex and difficult set of problems.

In addition, throughout the document, many statements and recommendations are made without supporting data and there is a limited diversity of cited authors. These omissions diminish the force and credibility of the document. For instance, Chapter VI (Homelessness) contains some relevant information about the issues of homelessness, mental disorders, and substance abuse. However, a more logical flow of the chapter is needed as are references to highly relevant research and evaluation studies funded by NIMH and CMHS. The authors have relied on old articles from a few authors. In order to do a credible review of what is known about the association between co-occurring disorders and homelessness and the treatment of homeless individuals, who also have co-occurring disorders, the authors need to examine the works of the following authors and their teams: Goldhnger, Hough, Rosenheck, Morse, Calsyn, Lehman, Breakey, Toro, and Caton. The report would also be strengthened if the there was familiarity with the ACCESS program evaluation funded first by NIMH and then CMHS. There are many other statements and recommendations that are presented without corroborating data. Several examples include:

- The arguments for increased funding in this report often lack an empirical basis, though such arguments could be developed. Requests for funding to conduct technical assistance workshops appear to have no empirical basis.

- Item 8 (p. 23) recommends that "a service provision design focusing on children with co-occurring disorders" be designed. However, to design service provisions presumes one has a theory or conceptual model of what is effective. What are the theoretical models that could be the basis for developing such a "service provision design" and what is the empirical evidence for its effectiveness?

- Objective II-B, "Identify and implement best treatment practices" recommends: 1. Collecting and disseminating information on 'successful integrated model programs.' What are the successful models that have been identified and what are the data as to the effectiveness of these successful integrated model programs?

  This objective also recommends reorganizing mental health and substance abuse services to provide **integrated services**. That makes a great deal of sense, but what are the models for doing so and where is the empirical evidence that it is more effective? Only one paper by Drake, et al. is cited.

- The recommendation on page 83 is to move research/demonstration funds away from continued research and toward implementation. This may be an appropriate recommendation, however, the authors of this chapter have not made an empirical case that the state of knowledge for treating homeless persons with co-occurring illness is sufficient for the Federal Government to abandon research in favor of treatment.

- One of the identified reasons for the report is to call "...the nation's attention to a recently emergent problem: Millions of individual with co-occurring substance related and mental health disorders." Does SAMHSA really consider co-occurring substance abuse and mental health disorders to be "recently emergent?"

- "The number of persons with co-occurring substance-related and mental disorders exploded into the millions by the 1980s." The report even acknowledges that we cannot be certain that these disorders did not exist by the millions in earlier decades since the first meaningful quantitative research which counted such persons was conducted in the 1980s.

- "...high percentages of inmates have co-occurring substance-related disorders and mental health disorders...although it was unintended, the manner in which deinstitutionalization was carried out **apparently** contributed to trans-institutionalization, from State and county mental hospitals to jails and prisons." While this may be a valid hypothesis, the claim requires supporting data.

- The "self-medication hypothesis" is not adequately described or supported. If it is not possible to do so, this should be acknowledged.

Objective I-D, strategy 2 recommends that SAMHSA and NIH focus their public information initiatives on co-occurring disorders. Although important, co-occurring alcohol, drug abuse, and mental health disorders are not and should not be an overriding NIH-wide issue. The NIH as a whole and the various institutes individually, have multiple research issues and diverse public information initiatives.

The report appears to endorse a very limited view of comorbidity. In the report, comorbidity appears to be conceptualized as multiple diagnoses utilizing the prevalent DSM-IV system of the American Psychiatric Association. There appears to be no realization that the issue of comorbidity is actually an indicate of the weaknesses of contemporary classification systems and the need to seek better methods of classification of syndromes. The role of clinical neurobiological measures such as those from SPECT or PET, may be seen as pivotal in making porgress in this area as behavioral measures by themselves have inherent limitations.

Goal I: Data and Research, p. 20 - Objective I-B, 5. What is meant by "NIH should establish **standards** on research grants that **require** grantees to collect relevant information on co-occurring disorders"?

Objective I-C calls for a data gathering system to obtain information on the co-occurring disorder population, including those not receiving treatment. This objective states that data should provide information on the costs, effectiveness, and outcomes of prevention and treatment services, but does not offer a suggestion as to how any data, including effectiveness of prevention services, could be collected on people not receiving treatment.

Objective II-A, item 2 - calls for design of prevention programs using what appears to be outdated terms. We suggest that the principles of prevention science as established by the Institute of Medicine and other recent reports be reviewed for more current information.

Thank you again for the opportunity to comment on the conference report. I hope these comments are helpful and constructive. The complexity of these issues will require long-term, ongoing collaboration among multiple agencies to meet the challenge of developing and implementing such a national strategy. Again, I believe that a cooperative effort to improve services to individuals with co-occurring disorders would be beneficial. We welcome the opportunity to work with SAMHSA and other Federal, State, and local organizations to develop such a national strategy. However, in light of NIH's limited participation in the development of this strategy and our concerns with its NIH-related components, NIH cannot concur with this the strategy as it has been presented in this report. Finally, a unified and collaborative process is necessary to effectively develop and implement such a comprehensive strategy. NIH would be pleaesd to work with SAMHSA towards this end.

Lana R. Skirboll

Lana R. Skirboll, Ph.D.

cc:
Dr. Bennett Fletcher
Dr. Robert Huebner
Mr. Geoffrey Laredo
Dr. Kathryn Magruder
Dr. Grayson Norquist
Mr. Jack Stein

Author's Update

By Bert Pepper, M.D.

It is immensely gratifying to see the publication of this report of an important invitational conference, sponsored by the National Advisory Council of SAMHSA. Delays in publication result in it appearing two years after the conference date, but better late than never.

As the person contracted to write the report of the conference, I must point out that the material in each chapter does not constitute a full literature review of the topic. That was not requested. SAMHSA requested introductory material to the recommendations of each of the tracks, in order to help readers understand how the topic plays into the overall situation of the perhaps 10 million Americans who simultaneously have a separately diagnosable mental disorder and substance-related disorder.

The numerous citations in the text of each chapter are, necessarily, limited to articles published 2 or more years ago. Much research is now under way, and a number of studies have been completed in the past year. They are notincluded in the text of this document, and readers who are interested will need to pursue the new research literature elsewhere.

The opening phrase of the Executive Summary has aroused controversy, for which I apologize. It says:

> **"The most common cause of psychiatric relapse today is the use of alcohol, marijuana, and cocaine.**
>
> **The most common cause of relapse to substance use/abuse today is untreated psychiatric disorder."**

The statement refers to my own clinical experience with truly dually disordered individuals. It does not apply to individuals who do not have a true mental disorder, but who have psychiatric symptoms which are

caused by their alcohol and/or drug use or abuse. In such individuals, abstinence alone will cause remission of the psychiatric symptoms, and no psychiatric or mental health treatment is required. My statement and this entire report refers to individuals who have an independent mental health disorder; one which persists even after prolonged abstinence from alcohol and other drugs.

There is no research base to support my statement: it is a clinical observation which I have offered to thousands of clinicians. None challenged it. Nevertheless, there is no research to support it.

The conference began at 9 a.m. on November 13, 1995. Later that morning President Clinton order the shutdown of the Executive Branch of the Federal Government, due to an impasse with Congress over the budget. Officially, Federal employees at the conference were ordered off duty. However, the invited conferees declined to leave, and decided to proceed. Many felt that they had traveled too far, both in years and miles, to discontinue this important task.

The conference proceeded, but under difficult circumstances. The general good cheer, enthusiasm, cooperation, and energy of the participants cannot be overstated. Everyone shifted gears and pitched in to fill the blanks left by departed Federal employees. Nevertheless, the reports of each of the seven tracks would doubtless have been better refined and clarified if the conference had been able to run on a normal track. The reports were faithfully reflected in the text, as submitted by the Federal reporters, and constitute the basis for the Proposed National Strategy.

In proposing a National Strategy, including needed actions and responsibilities to various governmental and nongovernmental entities, the goal was to create awareness of what needs to be done. There was no intent to find fault with any agency for actions which are not yet taken. Track participants were asked to brainstorm, to suggest what should be done, and also who might be called upon to do it.

Barbara Wagner, the SAMHSA staff person responsible for managing much of the conference's administration, also supervised me, the contracted author of this final report. It was she who, knowledgeable of Federal mandates for such conference reports, directed its format. Her great contribution to the conference and this report cannot be overstated.

Much controversy has proceeded, since the conference, on the recommendation of the Best Prevention and Treatment Practices Track, in favor of integrated treatment services. Within that track, there was a consensus for integrated rather than collaborative services.

As a separate matter, several tracks recommended that agencies be allowed to blend funds from various sources in order to improve treatment. Some participants specifically recommended that mental health and substance abuse Federal block grant monies might be blended. The recommendation for allowing blending of Federal Substance Abuse and Mental Health Block Grant Funds has been controversial. The Advisory Council of the Center for Substance Abuse Treatment has specifically objected to such a recommendation and, therefore also argued against the preference for integrated versus collaborative services.

In my opinion, these are two questions—integrated treatment services and blended block grant monies—which should stand separate and apart from each other. There was no controversy within the conference track regarding best treatment approaches: integrated services were clearly recommended over collaborative services. This issue should not be controlled by a concern about the integrity of the Federal Substance Abuse Block Grant. The tail should not wag the dog. The function of funding is to support services. It is not the function of services to support funding.

The conference was not asked to take up the issue of the mental health and substance abuse block grants, did not do so, and therefore this topic, while important, is only tangentially mentioned in the report. However, since it is an important topic, it might be advisable for SAMHSA to open a public

dialogue within its own component agencies and with the various state mental health and substance abuse authorities, to review this important issue.

Notwithstanding the conferee's—and this author's—preference for integrated treatment services, it is important for those who read this report to be aware of the enormous variety of individuals and disorders embraced under the term, co-occurring mental health and substance abuse-related disorders. The population is enormously varied in age, ethnicity, gender, sexual preference, economic status, as well as the range, extent, and nature of disorders, which may number between two and ten. Certainly there is no single treatment protocol that fits all sizes. Specific treatment approaches for the commonest subgroups within this heterogeneous population need to be worked out clinically and then tested by objective research. These are tasks for the future.

This report raises difficult issues. It cannot be over-emphasized that they are real, that they affect millions of people, that they have not been dealt with up to the present time, and that they cry out for appropriate attention. Perhaps this report will be a catalyst for a new way of looking at the issues, developing innovative responses to them, improving services, and thereby promising a better future for people with multiple mental health and substance-related disorders.

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